FINANCIAL REPORT

Fiscal Year 1993

Health Care Financing Administration

U.S. Department of Health and Human Services

Fiscal Year 1993

HCFA Financial Report

The Chief Financial Officers Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, it instituted a new Federal financial management structure and process modelled on private sector practices. The CFO Act establishes in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report.

This Financial Report is HCFA's second CFO Act submission. Its form and content follow guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects HCFA's strong support of the spirit and requirements of the CFO Act and our continuing commitment to improved agency financial reporting.

U.S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

HCFA Financial Report

Fiscal Year 1993

New National Headquarters of the Health Care Financing Administration (scheduled for occupancy in 1995)

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HCFA Financial Report

Fiscal Year 1993

Message from the Administrator

HCFA is the largest health insurer in the country. In Fiscal Year 1993, over 69 million beneficiaries received health care services through the Medicare and Medicaid programs; outlays approached $222 billion.

The fundamental mission of HCFA is to provide health security for Medicare and Medicaid beneficiaries. Health care security means:

- Access to affordable, quality health care services;
- Protection of the rights and dignity of beneficiaries; and,
- Provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

The ability of HCFA to fulfill its mission is dependent, among other things, on the financial integrity of Medicare and Medicaid and continuous improvement in the management and accountability of these programs.

As detailed in the body of this report, HCFA has been engaged in the important process of strategic planning. The over-arching purpose of this effort is ensure that our mission is fulfilled -- and that in doing so we promote improvement, excellence, and innovation in HCFA's programs.

We have defined our strategic vision, our basic mission, our primary customers, and our strategic goals. We are establishing structures and processes to involve each and every HCFA employee in improving the quality and efficiency of HCFA services. We will develop specific performance indicators to use to measure our progress in future financial statements.

A number of achievements over the past year illustrate how HCFA is adapting to a dynamic health care environment and embracing strategic vision and planning:

- Increased emphasis on beneficiary services;
- Streamlined approval of Medicaid waivers and demonstrations;
- Award of the Medicare Transaction System (MTS) contract to consolidate Medicare automated claims processing system with state-of-the-art computer technology; and,
- Extensive analysis of health care reform issues.

The purpose of these financial reports is to provide key information in a clear and concise manner so that policy makers, HCFA's customers and partners, and all other interested parties can easily see what we have done, where we have succeeded, and where there is opportunity for improvement. In that same spirit, we will continue to improve the agency's annual reports to make them more informative and comprehensive.

Bruce C. Vladeck
Administrator

April 1994

Message from the Chief Financial Officer

Throughout its existence, HCFA has been in a state of constant change as the Medicare and Medicaid programs have evolved through major legislative and policy innovations. Ranging from hospital prospective payment, managed care initiatives, physician payment reform, the explosive growth of Medicaid spending, continual budget reduction bills, and many others, HCFA has dealt with all of them while undergoing a 20% reduction in staffing and other pressures to rein in operating costs.

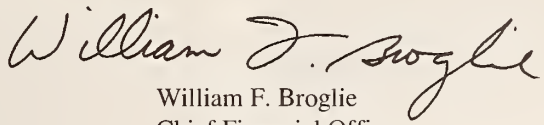
In Fiscal Year 1993, however, we entered a new phase of change: HCFA is now an agency in transition. The Medicare and Medicaid programs are facing fundamental reexamination as part of the health care reform debate, and the agency is fundamentally reexamining itself: our vision for the future, our mission, and long-range goals and objectives. Under the Clinton Administration, a new leadership team and a new agency structure are in place.

This year's Chief Financial Officer financial statements and report under P.L. 101-576 reflect HCFA's state of transition. The report both updates the information provided in HCFA's initial financial report and presents the current results of HCFA's new strategic planning process. As HCFA's strategic plans, goals, objectives, and critical success factors are further developed and refined, so too will our financial statements and report.

I am pleased to report that HCFA continues to make significant progress in addressing high risk areas and material weaknesses identified under the Federal Managers' Financial Integrity Act processes. One high risk area, Medicaid program data, was fully corrected. Four material weaknesses were closed out in FY 1993 (Medicaid Eligibility Quality Control Program, Paperwork Reduction Act, Medicare Credit Balances, and Separately Billable Drug and Blood Services under the End Stage Renal Disease Program) and one new one was declared (Medicare Contractor Accounts Receivable). In the high risk area of Medicare Secondary Payer (MSP), savings of $3.1 billion were achieved in FY 1993 and we are continuing to pursue further steps to improve MSP performance. In the area of internal controls for Medicare contractors, we identified over 5,000 alternative management control reviews conducted under ongoing quality assurance and oversight programs. We have also made considerable progress on curbing payments for unnecessary services, reducing duplicate payments for indirect medical education, improving grants and acquisition management, and reducing the backlog of overdue responses to Freedom of Information Act requests.

There have also been important accomplishments in the accounting area. Our initial efforts have focused on improving Medicare accounting by establishing a strong Medicare financial reporting network. This approach takes into account the unique partnership between HCFA and the Medicare contractors who carry out the day-to-day responsibilities of the Medicare program including paying Medicare bills, collecting overpayments, and settling claims. In FY 1993, we developed Financial Core Requirements requiring Medicare contractors to account for certain data elements, and implemented a standard reporting format designed to improve the accounting and reporting of Medicare receivables and payables. We worked closely with the Medicare contractor community to implement these changes. We formed a CFO Workgroup consisting of HCFA and Medicare contractor staff to improve reporting procedures so that all financial data would be reported accurately, consistently, and timely. I am confident that our efforts have not only improved Medicare reporting for FY 1993 but have established a strong foundation for further improvements in the future.

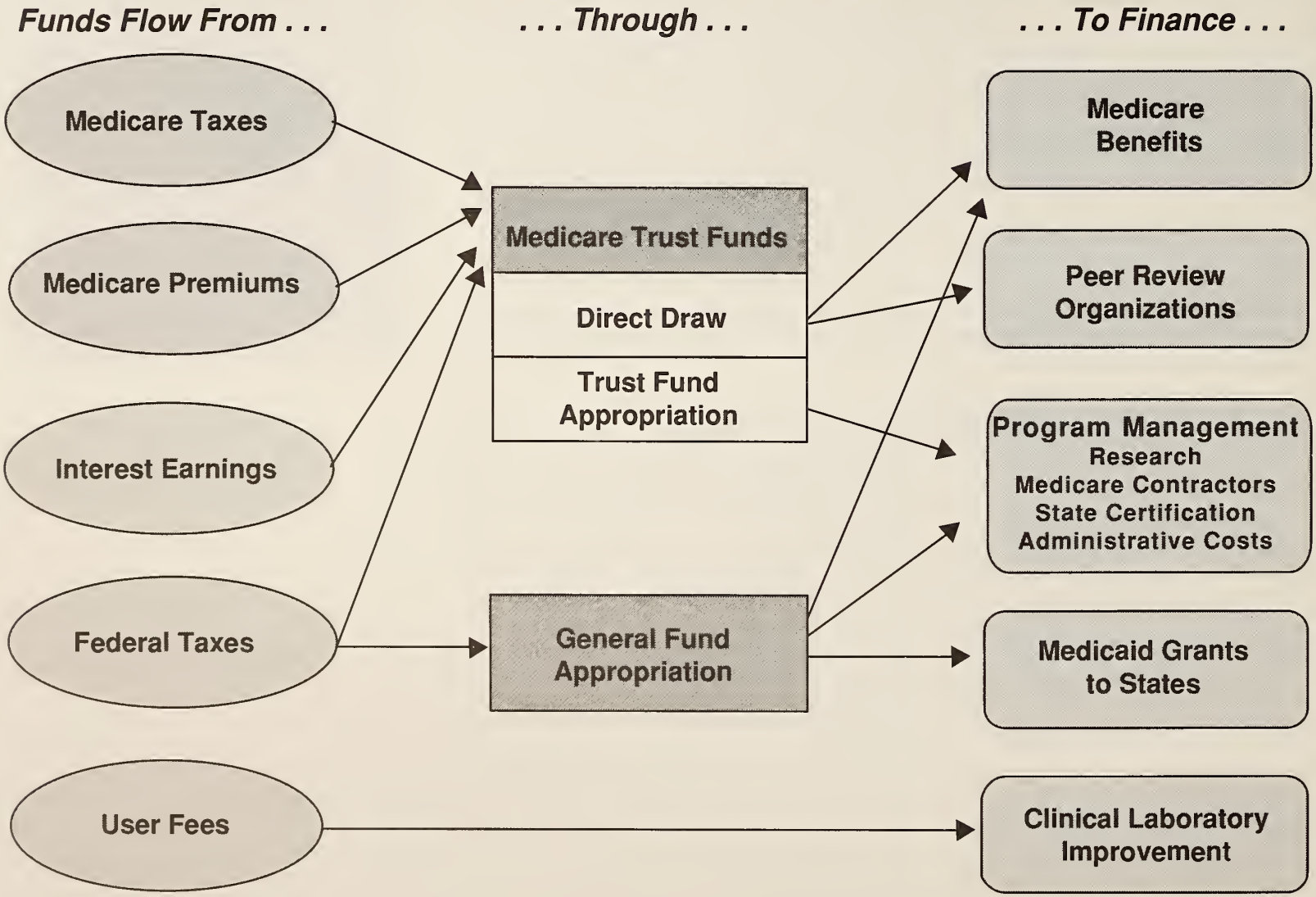
HCFA takes its financial management responsibilities very seriously. We will continue to improve our financial systems, accounting procedures, and reporting processes to reflect our goal to have the best financial management system in government.



William F. Broglie
Chief Financial Officer

April 1994

Financing of HCFA Programs & Operations



Chapter 1

Executive Summary

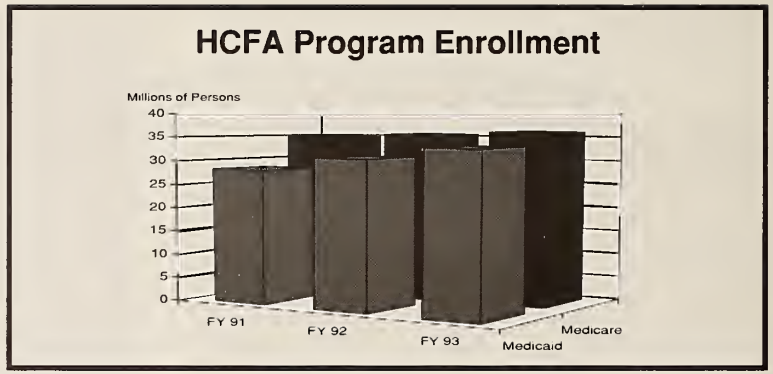
HCFA currently administers national health insurance programs for America's aged, disabled, those with end-stage renal disease, and many of the poor. Medicare had 36.1 million beneficiaries and outlayed $143 billion for health care services in FY 1993; Medicaid, administered jointly with the States, had 33.4 million enrollees and paid $131.8 billion for health care in FY 1993.

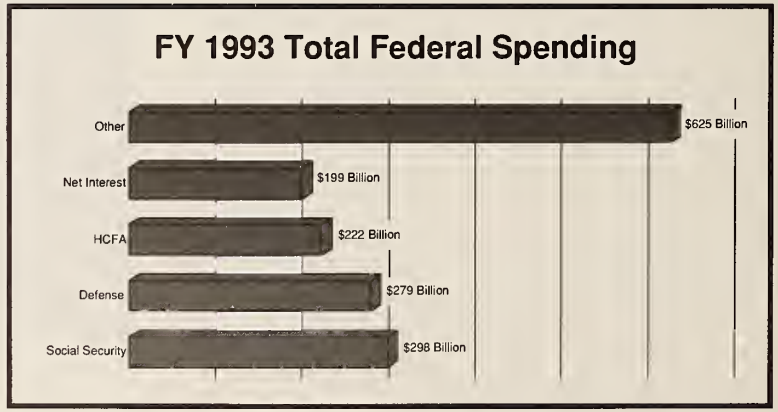
HCFA's total FY 1993 outlays of about $222 billion equaled 14% of the total Federal budget, and is the third largest share of Federal spending after Social Security and Defense. HCFA spending increased 10.8 percent from FY 1992 to FY 1993, over three times faster than the general cost of living as measured by the Consumer Price Index, and twice as fast as the CPI for medical goods and services. Medicare spending grew 10.3 percent and Medicaid spending rose 11.7 percent.

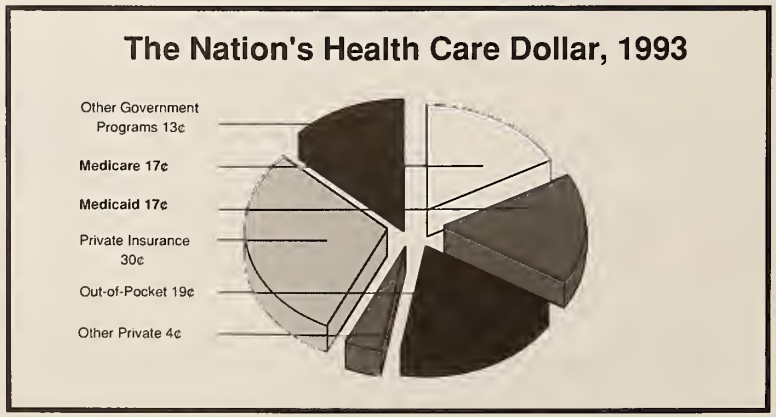
Medicare and Medicaid expenditures represented 34 cents of every dollar spent on health care in the United States--44 cents of every dollar received by U.S. hospitals, and 27 cents of every dollar received by other health care providers.

In addition to establishing rules for eligibility and benefit payments, paying Medicare benefits and providing States with matching funds for Medicaid benefits, HCFA carries out many other important activities:

- HCFA is responsible for assuring the safety and quality of medical facilities, providers, and suppliers through setting standards, conducting inspections, and certifying providers as eligible for program payments, and ensuring that corrective







actions are taken where deficiencies are found. HCFA also monitors the quality of care provided to Medicare beneficiaries through the Peer Review Organization (PRO) program.

- HCFA conducts an extensive program of research, demonstrations, and grants aimed at helping improve the quality of health care, access to care, the efficiency of delivery and payment systems, and other important improvements in the health care system.
- HCFA maintains the Nation's largest collection of health care data and provides data and analytical services to the Congress, other parts of the Executive Branch, non-government analysts and researchers, as well as internal users.
- HCFA promotes managed care and assures that Federally qualified HMO's meet quality, benefit, and financial integrity standards.
- HCFA, through the Clinical Laboratory Improvement Act (CLIA) program, helps assure the quality and reliability of laboratory testing for all Americans.
- HCFA oversees State regulation of private Medigap insurance to ensure that Medicare beneficiaries are afforded important consumer protections.

To accomplish its mission, HCFA is staffed by just over 4,100 Federal employees, but carries out most operational activities through contractors, as follows: 1) 28,500 employees at 81 claims processing contractors, 2) 6,700 employees at 53 State survey agencies, 3) 3,200 employees at 53 Peer Review Organizations, and 4) approximately 40,000 employees in State Medicaid agencies. The Social Security Administration and other Federal agencies also provide thousands of other staff either full or part-time for Medicare or Medicaid operations.

2,600 HCFA headquarters staff located in Baltimore and Washington are engaged in policy development, direction, and coordination; operational guidance and monitoring; survey and certification management; legislative planning; research; data and systems management; public information and liaison; and administrative services. 1,500 regional staff in 10 locations around the country oversee HCFA operations in their areas and deal directly with Medicare contractors, State agencies, providers, program beneficiaries and the general public.

Program Management encompasses the funding, through the annual Labor/HHS/Education Appropriations Act, of the operational and administrative expenses of Medicare, the Federal portion of Medicaid, and other agency responsibilities. There are four principal budget activities within Program Management--

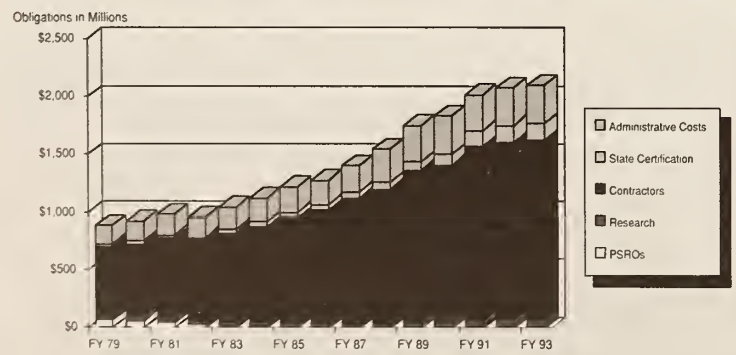
- Medicare Contractors
- Administrative Costs
- State Certification
- Research

Since FY 1979, Program Management costs have increased at an average annual rate of eight percent, while benefit outlays have grown 13 percent per year, on average.

Some of the same forces driving up program benefit costs also affect HCFA's operational costs, such as the aging of the population (not only resulting in increasing program enrollment but increased use of medical services), but HCFA has so far succeeded in increasing operational efficiency and productivity to keep the rate of Program Management cost increases to a reasonable level. This seems increasingly difficult each succeeding year, however, as the numbers of beneficiaries and associated workloads continue to grow and HCFA's work becomes more complex.

Program Management outlays decreased slightly from $2.1 billion in FY 1992 to about $2.0 billion in FY 1993.

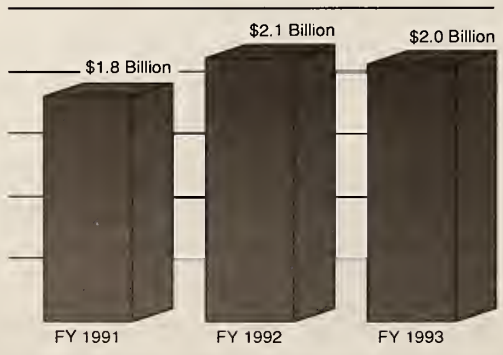
Program Management Obligations by Activity



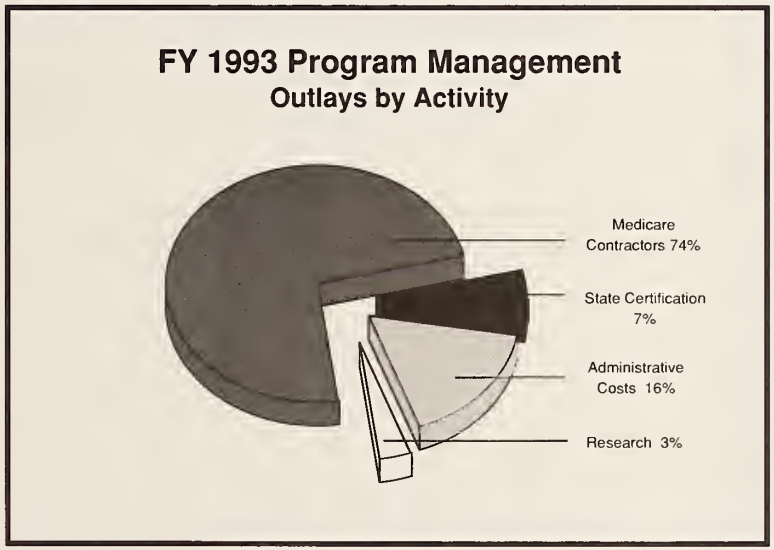
Medicare contractor spending comprises nearly three quarters of Program Management outlays.

Recognizing the severe restraints appropriated discretionary funding will continue to face even as mandatory entitlements such as Medicare and Medicaid expand rapidly, we are committed to a comprehensive program of productivity, service, and quality improvement. In FY 1993 we began developing the HCFA strategic plan, aggressively implemented programs to empower HCFA employees to develop process improvements, and planned the Medicare Transaction System and specialized contractors for Durable Medical Equipment. HCFA faces increasingly difficult challenges in the years ahead and we are moving aggressively to prepare ourselves for the future.

Program Management Spending



We were pleased that the Inspector General's 1993 survey of Medicare beneficiary satisfaction found that most



beneficiaries said the Medicare program was understandable, that they were able to get general Medicare information when they needed it, and that they were satisfied with Medicare claims processing. To ensure continuous focus on improving the quality and efficiency of all aspects of HCFA's work and to prepare for future changes in the Nation's health care delivery and financing systems, HCFA is currently engaged in a comprehensive strategic planning activity. This activity defines HCFA's vision for the future, its basic mission, and strategic goals.

To be completed in 1994, HCFA's strategic plan will include specific performance indicators, or critical success factors, by which progress toward achieving strategic goals can be measured. In future financial reports, we plan to key the information presented to the strategic plan. The HCFA strategic plan is discussed further in the next section of this overview.

The HCFA strategic plan will be the organizing focus for all HCFA activities, both our ongoing responsibilities and our preparations for the future. HCFA faces many important issues, and if past experience is any guide, unanticipated issues will develop which will require us to adjust and refine our plans and priorities. Some of the major issues HCFA faces include:

- Continuing, though recently abated, program cost increases straining Trust Fund solvency and general fund deficits requiring further budget reductions;
- Preparing to implement HCFA's part of health care reform;
- Implementing National Performance Review recommendations to streamline internal processes and eliminate barriers to efficiency;
- Developing and implementing a national health care database which will lead the nation in health care information resources management;

- Designing and developing a Medicare Transaction System which will standardize and improve the efficiency of Medicare claims processing;
- Enhancing beneficiary choice by expanding the participation of managed care programs in Medicare as a cost-effective alternative to fee-for-service;
- Assisting States to develop and implement Medicaid reform initiatives;
- Improving beneficiary access to quality health care in all sectors of State Medicaid programs;
- Promoting beneficiary awareness and understanding by enhancing educational, informational, and outreach activities with beneficiary, professional, provider, and business organizations;
- Reducing program costs through increased fiscal reviews, third party oversight, and secondary payer activities; and
- Planning a phased move into a consolidated headquarters building now under construction.

Chapter 2

HCFA Strategic Plan

HCFA's strategic plan sets forth the agency's mission and vision, and the goals, objectives and strategies we will pursue to reach our vision. Through strategic planning, HCFA is preparing carefully and purposefully for the future. The plan's goals, objectives, and strategies are not static but will be updated as our environment and priorities change. HCFA is committed to incorporating strategic thinking in performing our everyday work.

HCFA's strategic plan is unified by several underlying, recurring themes:

Investing in our employees
Improved service to beneficiaries
Building partnerships and teamwork
Improved communications
More efficient utilization of resources

If we are to be successful, we must empower our staff and use customer-defined needs as the primary means of improving our processes, evaluating our ability to serve, and establishing the partnerships and team arrangements needed for the sake of our customers.

The HCFA strategic plan will be used in budget formulation and work planning. Senior managers in HCFA recognize the importance of updating the plan periodically to reflect changes in program and operational activities as well as reporting accomplishments achieved under the strategic plan. The HCFA strategic plan reflects our commitment to becoming better leaders and improving the quality of the agency's activities in order to best serve our customers. The strategic plan also demonstrates HCFA's total commitment to become a proactive agency.

OUR MISSION

WE ASSURE HEALTH CARE SECURITY FOR BENEFICIARIES

Health care security means:

- Access to affordable, and quality health care services;
- Protection of the rights and dignity of beneficiaries; and,
- Provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

In serving the health care security needs of beneficiaries, we work together as a team and in partnership with others, and value the contributions each of us makes.

OUR VISION FOR THE FUTURE

WE GUARANTEE EQUAL ACCESS TO THE BEST HEALTH CARE

The vision reflects our commitment that:

- All individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income, or other circumstances; and
- The quality of health care they receive is the best that can be provided.

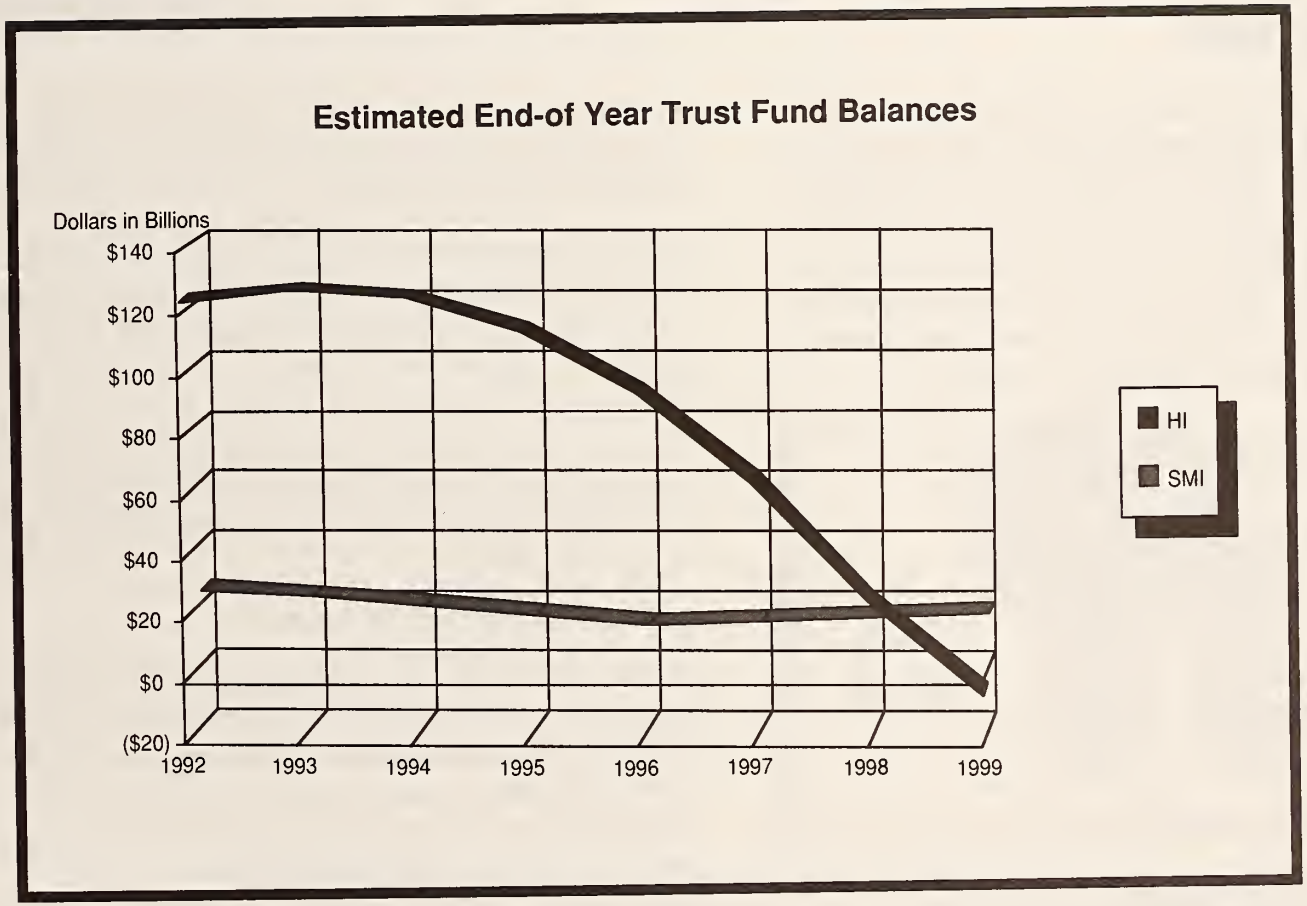
GOALS

Each goal will be supported by a set of objectives, which in turn will be supported by a set of strategies. Critical success factors are currently being developed to measure our progress toward meeting our goals. These will be included in next year's financial report.

HCFA's strategic goals, which are not yet final, will deal with such areas as building a high quality, customer-focused team; ensuring that programs and services respond to the health care needs of beneficiaries; promoting improved health status of beneficiaries; being a leader in health care information resources management; promoting the fiscal integrity of HCFA programs; and providing leadership in the continuing evolution of the health care system.

Chapter 3

Medicare

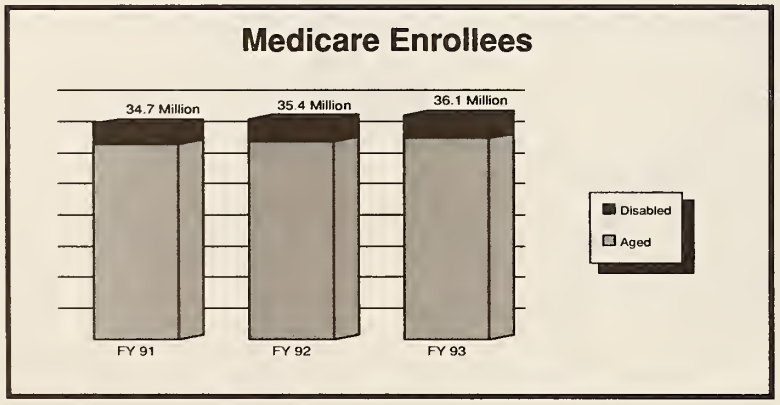


Key Fact

The 1993 Trustees Report of the Hospital Insurance Trust Fund projected depletion of the fund in 1999.

Program Profile

Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people 65 years old and older. Since 1966, when Medicare was implemented, the program has been broadened to cover the disabled, people with end-stage renal disease, and certain others who elect to purchase Medicare coverage.



Medicare is a combination of two programs, each with its own enrollment, coverage, and financing--Hospital Insurance and Supplementary Medical Insurance.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is generally provided automatically to people age 65 and over who have worked long enough to qualify for Social Security benefits, and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays participating hospitals, skilled nursing facilities, home health agencies, and hospice providers for covered services rendered to Part A enrollees.

Part A is financed through the HI Trust Fund, whose revenues come primarily through Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). In 1993, the Medicare payroll tax rate was 2.9 percent of annual wages up to $135,000--1.45 percent from employees and 1.45 percent from their employers. The self-employed paid the full 2.9 percent.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people age 65 and over, and disabled people entitled to Part A. SMI covers physician and outpatient care, laboratory tests, durable medical equipment, some therapy services, and some other services not covered by HI.

SMI coverage is optional, and subject to monthly premium payments by beneficiaries. About 95 percent of HI enrollees elect to enroll in SMI.

The 1993 SMI premium, set by statute, was $36.60 per month. Beneficiary premiums covered about 26 percent of SMI costs. The remaining cost were covered by appropriated Federal general revenues.

FY 1993 Highlights

Status of the Trust Funds

The 1993 Report of the HI Board of Trustees projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 1999. The Trustees (the Secretaries of the Treasury, Health and Human Services, and Labor, and two public trustees) recommended that legislative action be taken to bring the HI program into actuarial balance.

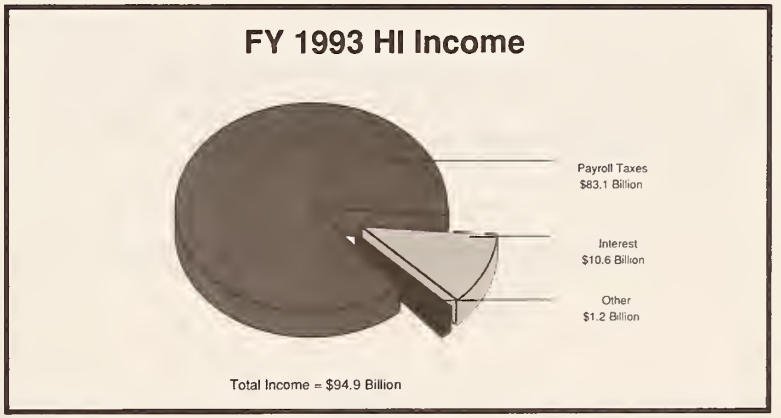
Unlike HI, which is financed primarily by payroll tax revenues based on statutory provisions covering several years, most current SMI costs are financed on a current-year basis through appropriations of Federal general revenues and beneficiary premiums. The SMI Board of Trustees reported that the SMI program is actuarially sound, but noted that the rapid rate of program outlay growth requires legislative action to control SMI costs.

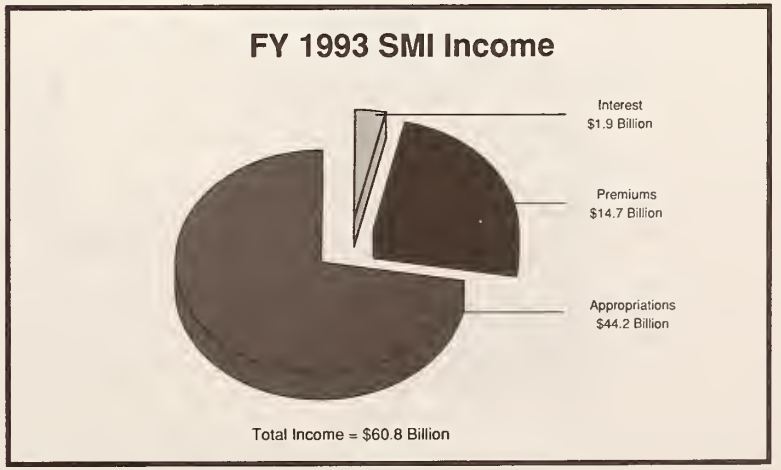
The 1994 Reports of the Boards of Trustees of the HI and SMI Trust Funds will be issued soon and will show revised projections based on more recent data.

Trust Fund Income

Medicare Trust Fund income totaled $155.7 billion in FY 1993, a seven percent increase over FY 1992, compared with the 10.3 percent increase in Medicare outlays.

HI Trust Fund receipts were $94.9 billion, three percent more than FY 1992. SMI income rose almost 15 percent to $60.8 billion. In addition, $1.8 billion in Catastrophic assets were transferred from SMI to HI.

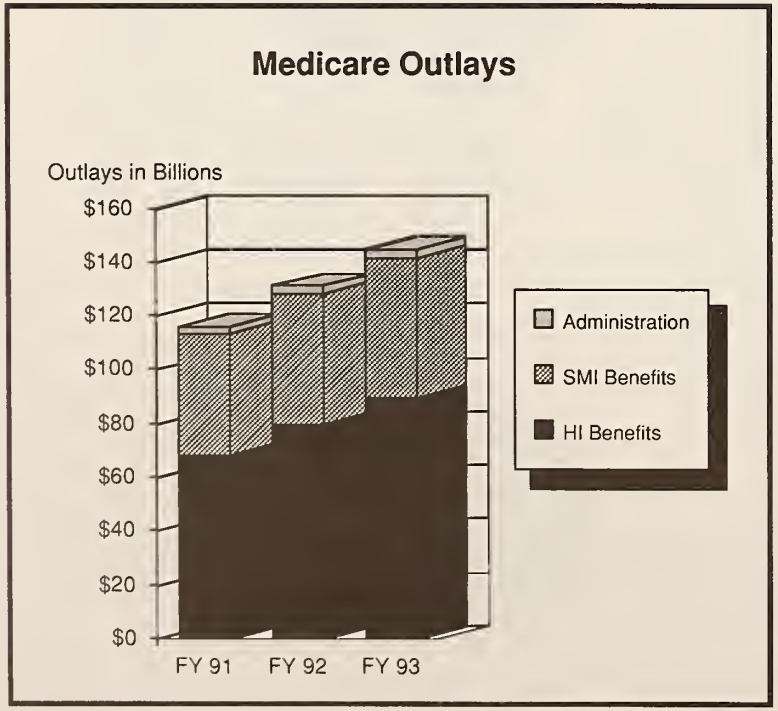




The HI Trust Fund income to outgo ratio was $1.04 to $1.00, down eight percent from FY 1992. The SMI Trust Fund increased six percent to take in $1.12 for each $1.00 outlayed.

Trust Fund Outlays

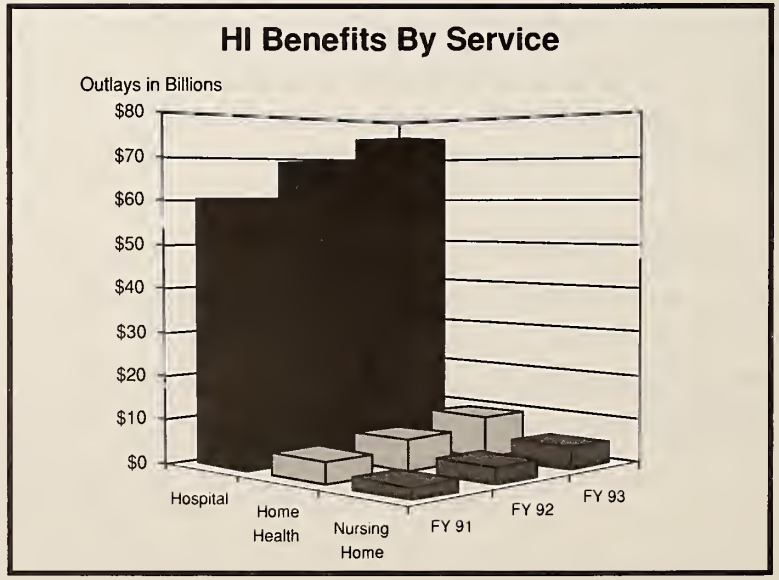
Total Medicare outlays, including benefit payments, Peer Review Organization spending and administrative costs, increased 10.3 percent over FY 1992. HI grew at an 11.8 percent rate, while SMI rose 7.9 percent.



Medicare Benefit Payments

Benefit payments accounted for about 98 percent of total spending. HI benefit payments benefit payments rose 12.3 percent, SMI benefits 7.8 percent.

Most HI growth was due to increased payments for inpatient hospital services, which comprised more than 80 percent of HI benefits. Hospital payment growth was driven by both increased hospital admissions and higher costs per admission. Spending for skilled nursing facility care, home health care, and hospice care continued to rise at a much faster rate, but these services constitute a much smaller portion of total HI outlays.

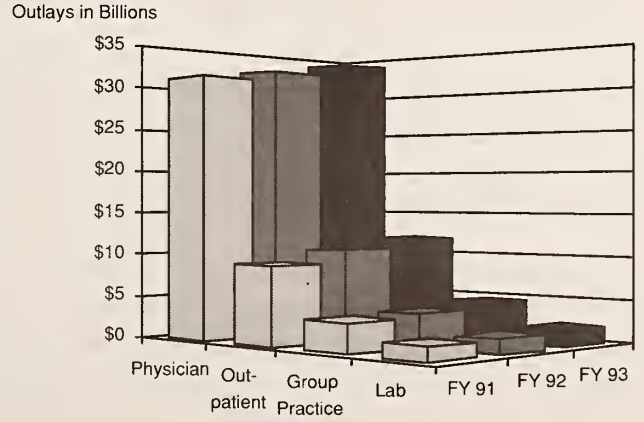


Of the $10.0 billion increase in HI benefits, inpatient hospital spending accounted for $5.9 billion or 59 percent. Home health spending comprised only 10.5 percent of total spending but 25 percent of the FY 1993 increase.

SMI benefits grew at a more modest 7.8 percent, but still far outpaced general inflation. Physician services, the largest component of SMI spending, grew 4.6 percent and accounted for nearly 40 percent of the 1993 increase.

Though only constituting 23 percent of SMI benefits, payments for outpatient services accounted for nearly 33 percent of FY 1993 SMI growth.

SMI Benefits By Service

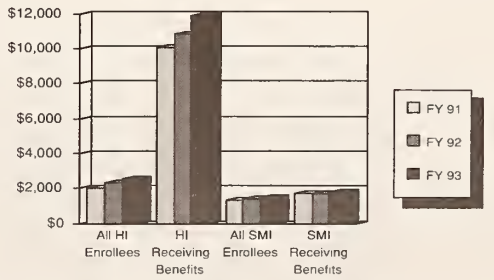


HI benefits per enrollee rose 8.9 percent to $2,553. However, less than 22 percent of HI enrollees received benefits in FY 1993--thus, spending per enrollee receiving services was much higher: $11,873. SMI benefits per enrollee increased 5.5 percent to $1,525. Spending per enrollee receiving services was $1,822.

Medicare Administrative Costs

Spending on Peer Review Organization, administrative and other non-benefit costs totaled $2.6 billion, a seven percent decrease from FY 1992. Peer Review Organization outlays

Medicare Benefits Per Enrollee



comprised over eight percent of the FY 1993 Medicare administrative outlays. HCFA Program Management costs attributed to the Medicare program accounted for 66 percent. The remainder went to the Social Security

Administration and other Federal agencies providing Medicare program support.

Peer Review Organizations (PROs). The PRO program, initiated in 1984, is the primary Federal effort to monitor the quality of care provided to Medicare beneficiaries. The PRO program's mission is to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and of acceptable quality.

PROs carry out their mission primarily by reviewing the medical records of a statistical sample of Medicare inpatient and outpatient hospital cases. In FY 1993 HCFA administered 53 PRO contracts: one per State, the District of Columbia, the Virgin Islands, and Puerto Rico.

Under Federal budget rules, the PRO program is defined as "mandatory" rather than "discretionary" because, like Medicare benefits payments, PRO costs are financed directly from the Trust Funds and are not subject to the annual appropriations process. PRO Trust Fund outlays in FY 1993 totaled $214 million, $18 million or eight percent less than in FY 1992.

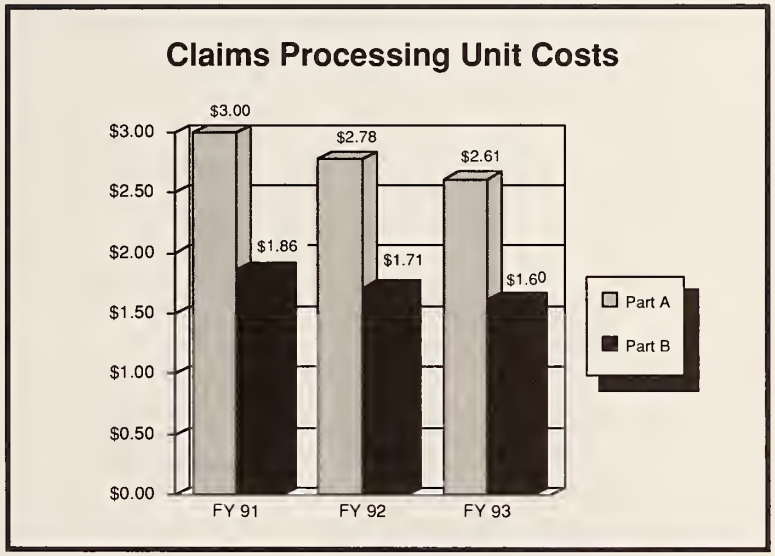
The decrease in PRO outlays is largely attributable to workload reductions. In FY 1993, PROs conducted fewer reviews than in FY 1992, primarily because HCFA reduced the sample of reviews for contracts beginning in FY 1993. HCFA also believes that retrospective PRO reviews have become less productive, as evidenced by a key productivity measure, the payment denial rate. Discontinuing inefficient workloads is one key component of HCFA's larger plans to overhaul the PRO program.

HCFA is refining a new strategy, known as the Health Care Quality Improvement Program (HCQIP), to better ensure Medicare quality of care. Under HCQIP, statistical and epidemiological analyses of patterns of care and outcomes are replacing the current system of reviewing individual medical records. In FY 1993, HCFA continued to use the experience of six pilot study PROs to chart the implementation strategy for this ambitious new undertaking.

Program Management. 81 HCFA contractors provided local administration of the Medicare program in FY 1993. **Medicare contractors** review and pay benefit claims, respond to beneficiary and provider inquiries, audit providers, conduct hearings and appeals, and carry out other claims-related work. There are 46 fiscal intermediaries handling HI (and some SMI) and 35 carriers handling SMI.

In FY 1993, Medicare contractor expenditures held steady at $1.5 billion. At the same time, the processed workload for Part A bills increased by eight percent, and by five percent for Part B claims.

HCFA continued to bridge the growing gap between workload and contractor funding through unit cost reduction. Contract negotiations, special initiatives, and contractor evaluation policies stressed the importance of lowering unit costs in individual contracts and reducing variation among contractors.

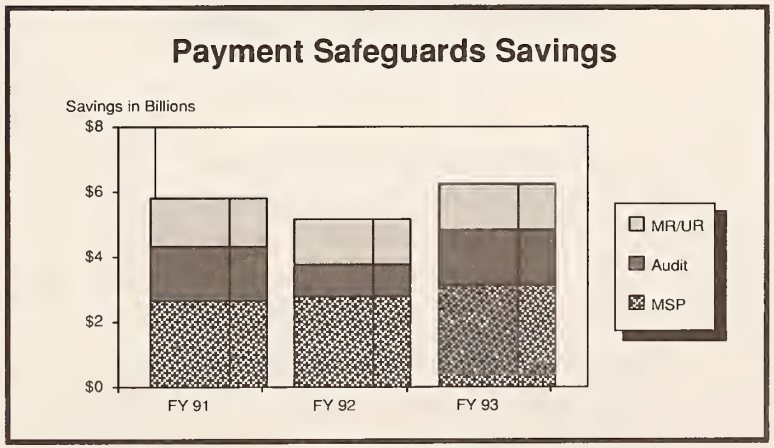


Target unit costs were set that incorporated industrial engineering study results demonstrating that much of the variation in contractor unit costs is attributable to differences in contractor claims mixes. By building a workload complexity index into target unit cost calculations, HCFA was able to reduce variation by more accurately portraying each contractor's costs relative to the national average. Also, by stressing the importance of electronic claims submission, HCFA was able to reduce unit costs overall.

While claims processing costs decreased, the end-of-year backlog pending as a percent of claims processed remained stable for Part A at 1.5 percent and decreased from 2 percent to 1.8 percent for Part B.

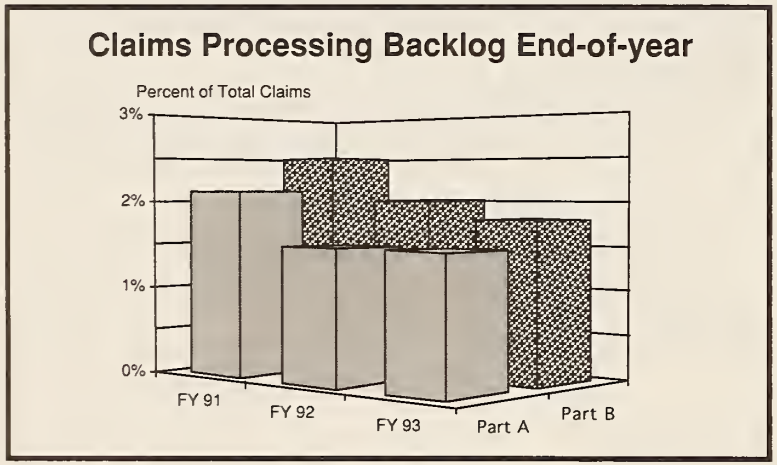
The Medicare contractors carry out a range of activities, collectively known as "payment safeguards", to prevent and recover inappropriate Medicare benefit payments. Over the past several years, these payment safeguards have returned significant savings to the Trust Funds. Payment safeguards include:

- Medicare Secondary Payer (MSP)--identification of instances where other insurance should be primary.
- Audits of Medicare providers.
- Medical Review and Utilization Review (MR/UR).
- Fraud and abuse detection.



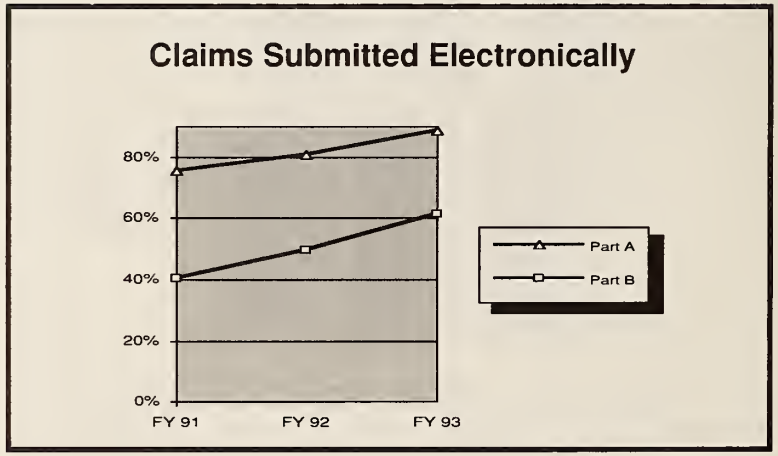
Beginning in FY 1993, HCFA changed the MR/UR program to emphasize preventing the delivery of inappropriate services rather than denying billed services. A methodology is being developed to measure the effectiveness of this approach.

The magnitude of FY 1993 Medicare payment safeguard savings illustrates that funding of payment safeguards is a sound investment. Each approriated payment safeguard dollar leads to savings of many more benefit dollars.



In addition to payment safeguards investments, HCFA invested $76 million in Medicare contractor productivity investments. These include initiatives to encourage efficiency and improve Medicare program administration. In FY 1993, these investments included:

- Moving durable medical equipment claims processing from Part B carriers to specialized regional carriers.
- Continuing to support the maintenance and processing of claims through shared systems and improving large-volume systems with state-of-the-art technologies in order to maximize efficiencies.
- Intensifying marketing efforts directed toward providers for electronically-submitted claims, which are the largest contributors to unit cost reduction for contractors.

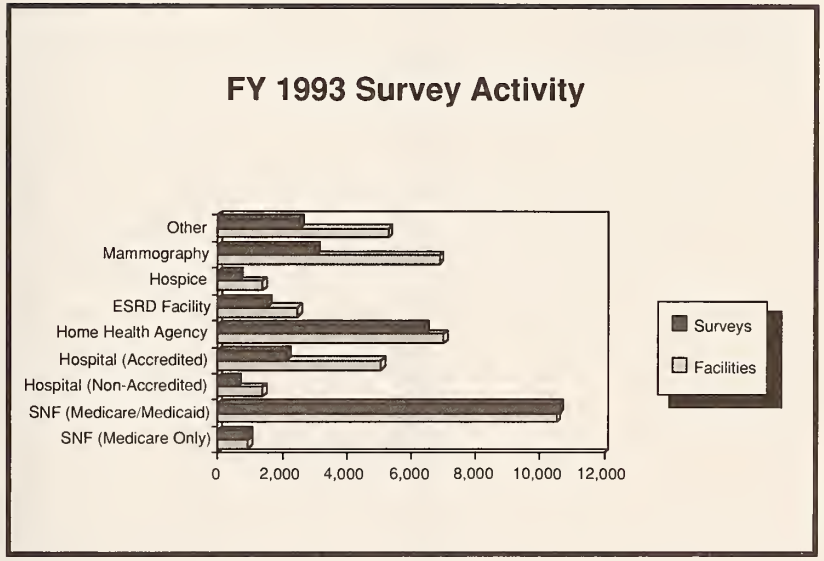


The mission of the **State Survey and Certification** program is to ensure that Medicare service providers and suppliers comply with Federal health, safety, and program standards. To meet this goal, HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Only certified providers and suppliers are eligible for Medicare payments. A companion Medicaid State certification program is funded through the Medicaid appropriation.

Spending totaled $136 million, an increase of two percent from FY 1992.

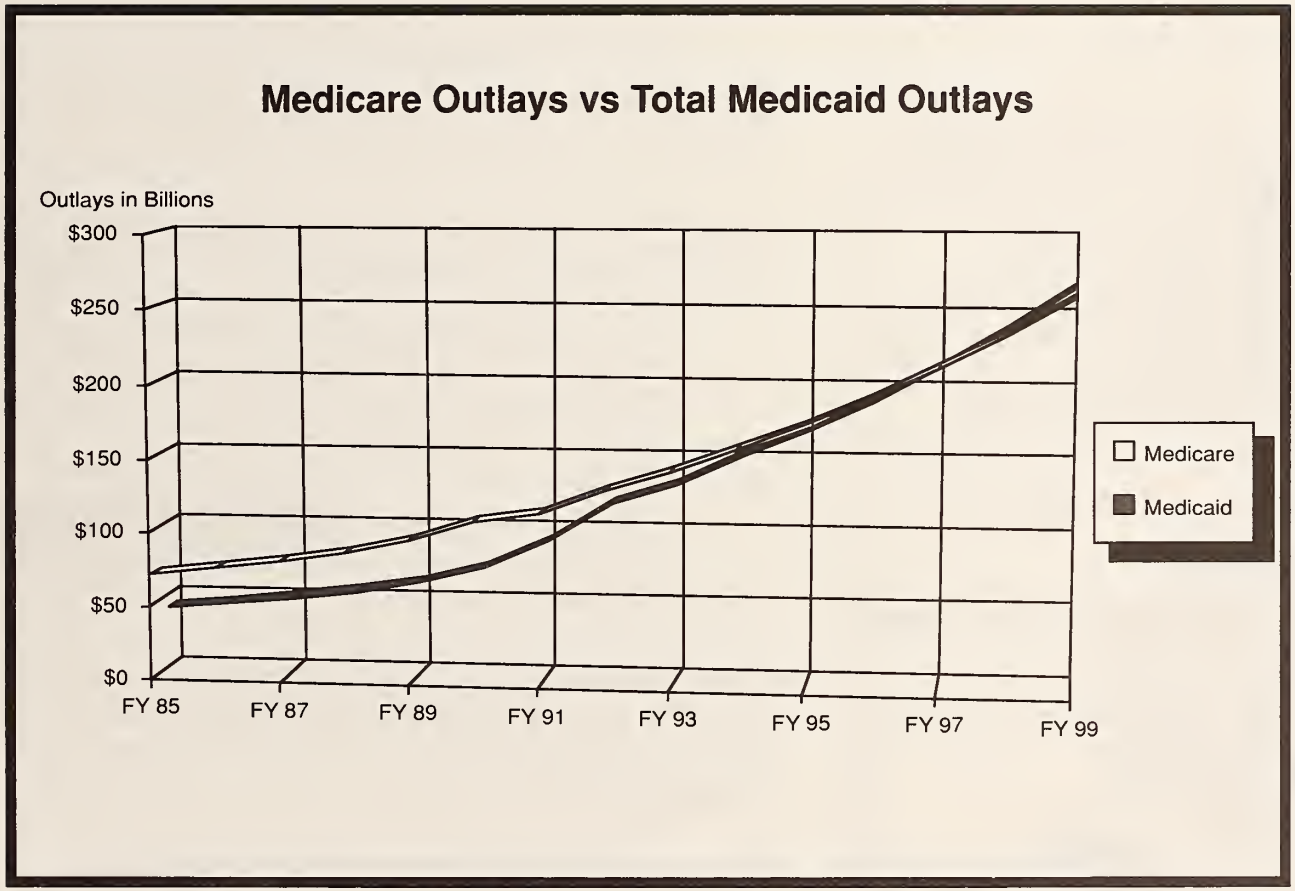
In FY 1993, State surveyors conducted 28,344 inspections and found 1,876 facilities out of compliance with basic Medicare conditions of program participation for a condition-level deficiency rate of 6.6 percent, slightly higher than 1992's condition-level deficiency rate of 5.9 percent. 18,399 facilities were cited for less serious, standard-level deficiencies in FY 1993. These facilities represented a 65 percent standard-level deficiency rate, slightly higher than FY 1992's 64.6 percent rate.

While most facilities rectified deficiencies through verified completion of corrective action plans, 98 others were involuntarily terminated from Medicare in FY 1993. Additionally, many providers facing the threat of termination chose to voluntarily withdraw from Medicare participation.



Chapter 4

Medicaid



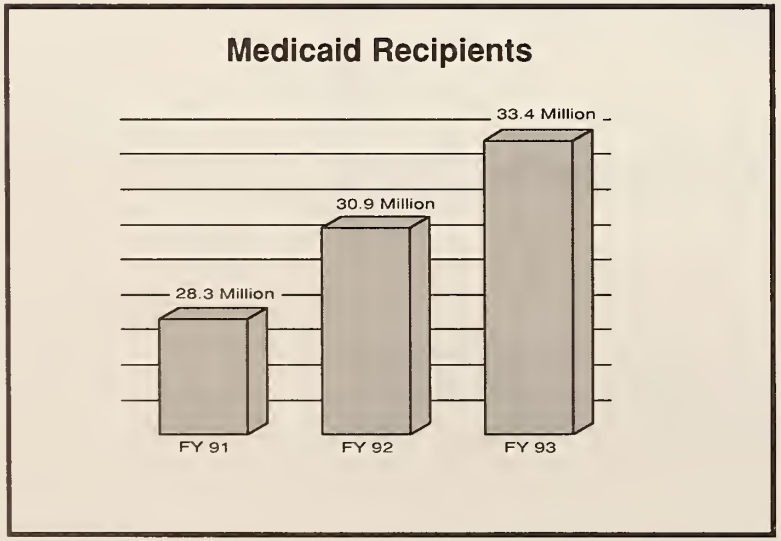
Key Fact

Combined Federal and State Medicaid spending is projected to surpass Medicare in 1998--though as recently as 1990 Medicare was 50 percent larger.

Program Profile

Medicaid is the means-tested health care program for low-income Americans, administered in partnership by States and the Federal government. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to welfare recipients. Over the years, however, Medicaid has been incrementally expanded well beyond the traditional welfare population. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including—

- poor families,
- the blind and disabled, and
- low-income elderly, disabled, and mentally retarded persons requiring long-term care.



One U.S. citizen in 9 was covered by Medicaid in fiscal year 1993.

Under Medicaid's division of responsibilities, HCFA provides matching payment grants to State governments.

- State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1993, the Federal matching rate ranged from 50 to 79 percent, with a national average of 57 percent.
- Federal matching rates for various State and local administrative costs are set by statute, and in 1993 averaged 56 percent.

Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/ Education Appropriations Act. There is no cap on Federal matching payments to States.

States set eligibility, coverage, and payment standards within broad Federal guidelines that include—

- Providing coverage to persons receiving Aid to Families with Dependent Children and Supplemental Security Income, to the medically needy, to low-income pregnant women and young children, to low-income Medicare beneficiaries, and to certain other groups.

- Covering 13 mandatory services, including hospital treatment, laboratory tests, family planning, nursing facility services, and health screening for children under age 21.

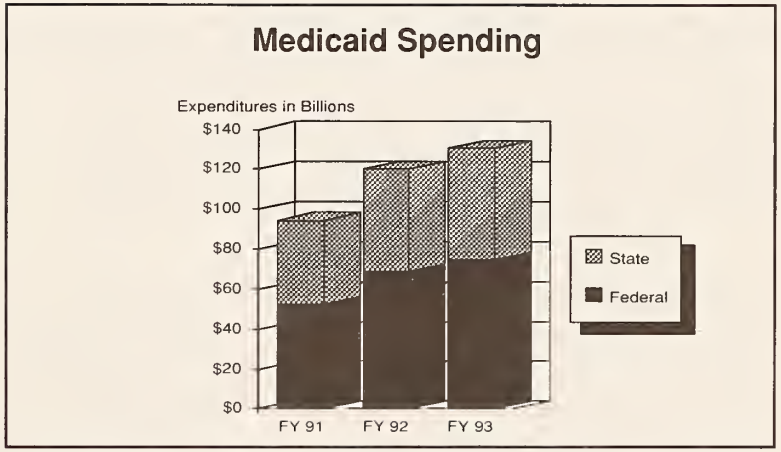
State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States. For example, 31 State Medicaid programs cover psychologist services, 50 cover dental services, and 15 cover services provided in Christian Science sanatoria.

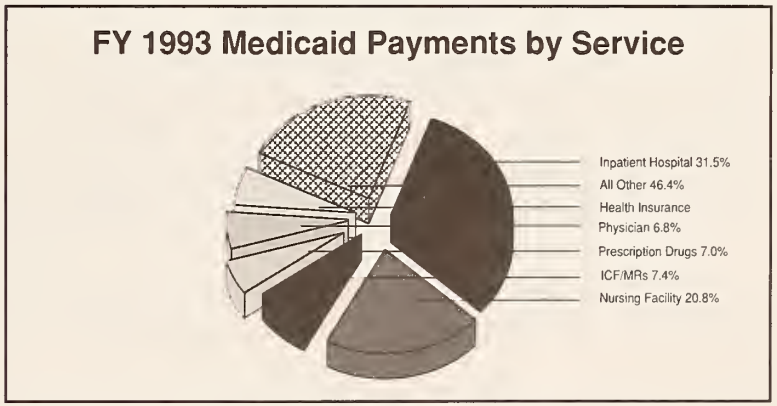
FY 1993 Highlights

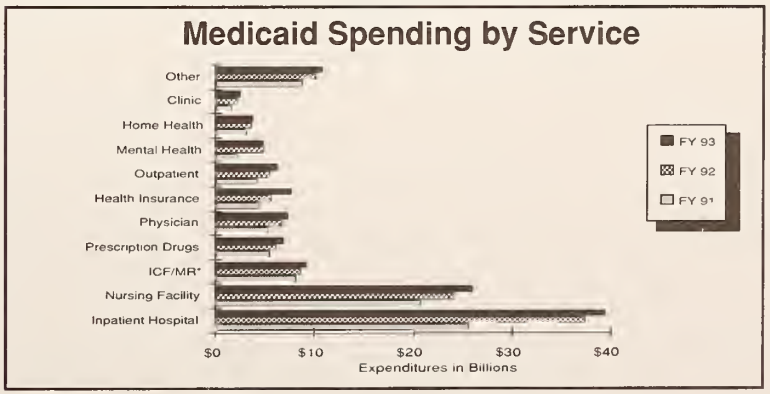
Combined Federal and State Medicaid outlays in FY1993 totaled $131.8 billion–$75.8 billion in Federal outlays and $56 billion in State outlays. Of the total outlays of $131.8 billion, medical assistance outlays totaled $126.6 billion and administration outlays totaled $5.2 billion. Combined Federal and State outlays in 1993 were $13.6 billion higher than in FY 1992, an 11.5 percent increase, well below FY 1991 to FY1992 25 percent increase.

Federal Medicaid outlays alone in FY 1993 increased $8 billion, or 11.8 percent over FY 1992 Federal outlays. Between FY 1991 and FY 1993, Federal oulays have increased by more than 44 percent.

Combined Federal and State medical assistance actual expenditures reported by the States in FY 1993 totaled $125.8 billion, an increase of $9.9 billion, or 8.5 percent over FY 1992. Inpatient hospital expenditures, which





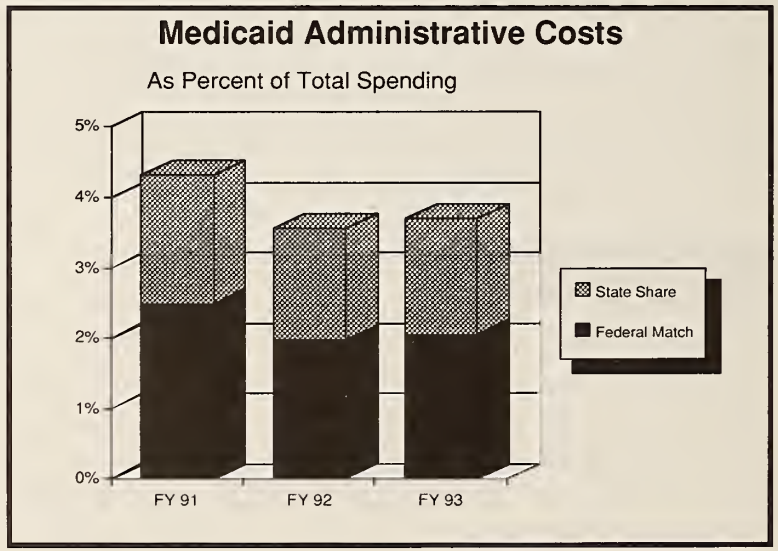


accounted for 32 percent of total expenditures in both FYs 1992 and 1993, comprised 21 percent of the FY 1993 medical assistance expenditure growth over FY 1992. Health insurance payments, which accounted for only 6 percent of total expenditures in FY 1993, comprised nearly 21 percent of the FY 1993 growth over FY 1992.

Children comprised about 49 percent of the Medicaid population, but accounted for only 16 percent of Medicaid outlays. In contrast, the elderly and disabled made up over a quarter of the Medicaid rolls, but accounted for about 68 percent of program spending.

Total Medicaid administrative outlays in FY 1993 grew 17.8 percent over FY 1992 outlays. For the first time in recent years, this rate of growth exceeded the medical assistance rate of growth. Medicaid administrative outlays in FY 1993 were 3.9 percent of total Medicaid outlays.

The FY 1993 growth rate is significantly lower than that of recent years. This appears to be due in part to several interacting factors: (1) A general slowdown in the rate of health care price inflation, (2) aggressive use of managed care and utilization management by States, (3) new limits on the ability of States to use tax and donation arrangements to leverage Medicaid funding, and (4) limits on disproportionate share hospital expenditures that took effect in FY 1993.



Financial Statements and Notes

COMBINED STATEMENT OF FINANCIAL POSITION
AS OF SEPTEMBER 30, 1993

ASSETS	(Dollars in Millions)
Financial Resources:	
Intragovernmental Items:	
Fund Balances *Note 2*	$14,190
Interest Receivable *Note 3*	3,113
Investments *Note 3*	149,346
Governmental Items:	
Accounts Receivable, Net *Note 4*	3,210
Loans Receivable, Net	23
Total Financial Resources	**$169,882**
Non-Financial Resources:	
Governmental:	
Advances and Prepayments	$2,411
Property and Equipment, Net	31
Total Non-Financial Resources	**$2,442**
TOTAL ASSETS	**$172,324**

LIABILITIES	(Dollars in Millions)
Funded Liabilities:	
Intragovernmental:	
Accounts Payable	$5
Suspense Account Deposit Funds	4
Governmental:	
Accounts Payable *Note 5*	14,160
Accrued Payroll and Benefits	5
Liabilities For Loan Guarantees	34
Deferred Revenue	184
Accrued Interest Payable	1
Total Funded Liabilities	**$14,393**
Unfunded Liabilities:	
Governmental:	
Accrued Leave	$18
Other Unfunded Liabilities *Note 6*	534
Total Unfunded Liabilities	**$552**
TOTAL LIABILITIES	**$14,945**
NET POSITION	
Fund Balances:	
Unexpended Appropriations	$157,739
Invested Capital	31
Other	161
Less: Future Funding Requirements	552
TOTAL NET POSITION *Note 7*	**$157,379**
TOTAL LIABILITIES & NET POSITION	**$172,324**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION FOR THE PERIOD ENDED SEPTEMBER 30, 1993

REVENUE AND FINANCING SOURCES	(Dollars in Millions)
Direct Appropriations Expended	$74,213
Employment Tax Revenue *Note 8*	83,138
SMI Premiums Collected *Note 9*	14,683
Federal Matching Contributions *Note 9*	44,227
Revenue From Sales of Goods/Services	
CLIA User Fees	34
Intragovernmental	5
Interest & Penalties (Non-Fed)	24
Interest (Fed)	12,550
Other Revenue and Financing Sources *Note 10*	1,339
Uncollected Revenue	(48)
Transfers to FDA Pursuant to P.L. 103-50	(1)
Less: Collections For Principal Repayments Transferred To The Federal Financing Bank	26
Taxes and Receipts Transferred To the Treasury or Other Agencies	57
Total Revenues and Financing Sources	**$230,081**
EXPENSES	
Program or Operating Expenses	
Medicare Benefit Payments *Note 11*	$135,681
Medicaid Benefit Payments *Note 11*	74,189
Administrative Expenses *Notes 11 and 12*	2,697
Other *Note 11*	26
Depreciation and Amortization	5
Interest Expense	11
Unfunded Expenses *Note 13*	(1,701)
Total Expenses	**$210,908**
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	$19,173
Net Position, Beginning Balance	128,537
Plus (Minus) Non-Operating Changes *Note 14*	9,669
Net Position, Ending Balance	**$157,379**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF CASH FLOWS
FOR THE PERIOD ENDED SEPTEMBER 30, 1993

CASH FLOWS FROM OPERATING ACTIVITIES	(Dollars in Millions)
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	$19,173
Adjustments Affecting Cash Flow	
Appropriations Expensed	($118,911)
Trust Fund Draws	(1,923)
Transfers to FDA Pursuant to P.L. 103-50	1
Decrease (Increase) in Accounts Receivable	(1,654)
Decrease (Increase) in Advances	14,419
Decrease (Increase) in Other Assets	41
Increase (Decrease) in Accounts Payable	(5,807)
Increase (Decrease) in Loans Payable	26
Increase (Decrease) in Interest Payable	1
Increase (Decrease) in Other Liabilities	(19)
Depreciation and Amortization	5
Other Unfunded Expenses	(1,523)
Suspense Account Deposit Funds	(2)
Total Adjustments	**($115,346)**
Net Cash Provided (Used) by Operating Activities	**($96,173)**
CASH FLOWS FROM INVESTING ACTIVITIES	
Purchases of Property and Equipment	($4)
Net Cash Provided (Used) by Non-Operating Activities	**($4)**
CASH FLOWS FROM FINANCING ACTIVITIES	
Appropriations	$112,623
Add: Transfers from Medicare Trust Funds	1,923
Transfers to FDA Pursuant to P.L. 103-50	(1)
Deduct: Withdrawals (M Year Funds)	1
Adjustment of Prior Year Cost Allocation	142
Net Appropriations	**$114,402**
Purchase of Investments	($10,166)
Repayments on Loans from the Treasury and the Federal Financing Bank	(26)
Net Cash Provided (Used) by Financing Activities	**$104,210**
Net Cash Provided (Used) by Operating, Non-Operating and Financing Activities	$8,033
Fund Balances With Treasury, Cash and Foreign Currency, Beginning	6,157
Fund Balances with Treasury, Cash and Foreign Currency, Ending	**$14,190**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF BUDGET AND ACTUAL EXPENSES FOR THE PERIOD ENDED SEPTEMBER 30, 1993

(Dollars in Millions)

BUDGET:		
Resources		**$246,724**
Direct Obligations	$215,974	
Reimbursed Obligations	6	
Total Obligations		**$215,980**
BUDGET RECONCILIATION:		
Actual Expenses		**$210,908**
Add:		
Capital Acquisitions		4
Less:		
Depreciation and Amortization		5
Unfunded Annual Leave Expense		1
Other Unfunded Expenses		(1,701)
Accrued Expenditures		**$212,607**
Less: Reimbursements		6
Accrued Expenditures, Direct		**$212,601**

The accompanying notes are an integral part of these statements.

Note 1: Summary of Significant Accounting Policies

Reporting Entity

The Health Care Financing Administration (HCFA) is considered a separate reporting entity of the Department of Health and Human Services (DHHS) for financial reporting purposes. The financial statements, required by the Chief Financial Officers Act of 1990, are prepared from HCFA's accounting records in accordance with the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 93-02 and subsequent issuances, DHHS's and HCFA's accounting policies which are summarized in these footnotes.

The financial statements include the accounts of all funds administered by HCFA which are discussed below.

Medicare Hospital Insurance (HI)

Medicare contractors are paid by HCFA as our agents to receive and process Medicare claims for hospital inpatient services, hospice and certain skilled nursing and home health services. Payments made by the Medicare contractors for these services are withdrawn from the HI trust fund.
This portion of the statements includes HI trust fund activities administered by the U.S. Department of Treasury.

Medicare Supplementary Medical Insurance (SMI)

Medicare contractors are also paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, chronic renal disease, rural health clinic, certain skilled nursing and home health services. Payments made by the Medicare contractors for these services are withdrawn from the SMI trust fund. This portion of the statements includes SMI trust fund activities administered by the U.S. Department of Treasury.

Medicaid

Medicaid, the health care program for low-income Americans, is administered in partnership by the States and the Federal government. Funds are advanced quarterly to States based on grant awards prepared by HCFA's Medicaid Bureau. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the Federal government's share of States' Medicaid costs. At the end of each quarter, States submit reports of their actual expenditures and subsequent grant awards are issued for the difference between actual expenditures reported for the period and the grant awards previously issued.

The financial statements include actual expenditures reported by States for the first three quarters of FY 1993 and an estimate for the fourth quarter. The estimate is an accrued amount based on the grant awards issued for the fourth quarter.

Program Management

The Program Management appropriation provides HCFA with the capacity to administer and oversee the Medicare and Medicaid programs. The funds for this activity are provided primarily by transfers from the HI and SMI trust funds. In addition, user fees collected from Health Maintenance Organizations seeking Federal qualification and reimbursement from other agencies for services performed for them by HCFA are credited to this appropriation. During FY 1993, the Payments to the Health Care Trust Funds appropriation paid the Medicare Trust Funds $117,862,000 to cover the Medicaid program's share of HCFA administrative costs. HCFA's cost allocation system determines the distribution of funds between the funding sources. All expenses chargeable to the Program Management appropriation, except HMO user fees and reimbursement from other agencies, are allocated to the Medicare HI and SMI and the Medicaid programs and are reported to those programs in the Supplemental Section of this report.

Funds are obtained from the HI and SMI trust funds as cash is needed to pay for Program Management appropriation expenses. During FY 1993, a total of $1,922,251,151 was obtained from the trust funds to cover cash outlays. Of this amount, $1,817,314,587 was needed to pay for expenses incurred against current year obligations and $104,936,564 was needed for expenses incurred against prior year obligations.

All Others

The following accounts are reported in the "All Others"column of the financial statements by activity.

1) SECA Credits

The Self-Employment Contribution Act provides for tax credits from the general funds of the Treasury. These credits represent the difference between the statutory SECA and the actual tax rate paid by the self-employed. The amounts reported in FY 1993 are adjustments to tax years 1984 through 1989.

2) Payments to the Health Care Trust Funds

The Social Security Act provides for payments to the Health Care Trust Funds for Supplementary Medical Insurance (appropriated funds to provide for federal matching of SMI premium collections), Hospital Insurance for the Uninsured and Federal Uninsured Payments. For purposes of financial statement presentation the revenue and expenses of this appropriation are reported only in the Medicare HI and SMI accounts.

3) Suspense

Agencies are required to deposit receipts expeditiously. Unidentified collections are deposited into a suspense account for immediate availability to Treasury while HCFA researches the actual application of funds.

4) Miscellaneous Fines, Penalties and Forfeitures

Civil monetary penalties and Freedom of Information administrative fees are assessed on overdue payments.

5) Interest Receipts

Interest resulting from debt collection is deposited to Treasury miscellaneous receipt accounts.

6) General Fund Receipts

The Freedom of Information Act provides for the proceeds from the sale of publications to be deposited to Treasury miscellaneous receipt accounts along with other miscellaneous recoveries and refunds.

7) Health Maintenance Organization (HMO) Loan Program

The Public Health Service's HMO program was transferred to HCFA in 1985. Included in this transfer was the HMO Loan and Loan Guarantee Fund, originally established to provide working capital to HMOs during their initial periods of operations and to guarantee loans made by private lender to HMOs.

The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers, and in turn pays the FFB.

8) Clinical Laboratory Improvement Amendments (CLIA)

The Clinical Laboratory Improvement Amendments of 1988 marked the first comprehensive Federal effort to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management.

Fees for registration, certificates and compliance determination of all U.S. clinical laboratories are collected to finance the program. Therefore, like the HMO program, the CLIA fund operates as a revolving fund.

9) Program Management

Activities related to HMO user fees and reimbursements from other agencies are reported here.

Basis of Accounting

Transactions are recorded on both an accrual and cash method. Under the accrual method, expenses are recognized when a liability is incurred without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed. The Medicare Program uses the cash method to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of fiscal year-end. Revenues are recognized when earned without regard to receipt of cash. Budgetary accounting facilitates compliance with legal constraints and controls over the use of Federal funds. HCFA uses the Government's Standard General Ledger account structure.

Funds with the U.S. Treasury and Cash

HCFA does not maintain cash in commercial bank accounts. Cash receipts and disbursements are processed by the U.S. Treasury with the exception of third party drafts which are primarily used to reimburse employees for travel expenses. Funds with Treasury are primarily available to pay current liabilities. Cash balances held by Treasury are reconciled each month to control records maintained by HCFA.

Investments

HCFA is required by Section 201(d) of the Social Security Act to invest HI and SMI Trust Fund holdings not necessary to meet current expenditures in "interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at amortized cost as determined by the U.S. Treasury. Interest income is compounded semi-annually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

Retirement Plan

HCFA's employees participate in the in the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to 7 percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management.

Most employees hired after December 31, 1983 are automatically covered by FERS. Employees hired prior to January 1, 1984, can elect either to join to join FERS or remain in CSRS. A primary feature of FERS is that it offers a savings plan to which HCFA is required to contribute 1 percent of pay and match employee contributions up to an additional 4 percent of pay.

For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

Estimation of Obligations Related to Cancelled Appropriations

As of September 30, 1993, HCFA has cancelled over $53 million in obligations to FYs 1988 and prior in accordance with Public Law 101-510. Based on the payments made in FYs 1991 through 1993 related to cancelled appropriations, HCFA anticipates an additional $8.7 million will be paid from current year funds for cancelled obligations.

Comparative Data

Comparative Data for the prior year have not been presented because the format for the FY 1993 Financial Statements is materially different from the format used in FY 1992. The change in format involved primarily the presentation of the Program Management appropriation. In future years, comparative data will be presented.

Limitations to the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of HCFA as required by the Chief Financial Officers Act of 1990.

While the statements have been prepared from HCFA's books and records in accordance with guidance from the Office of Management and Budget, the statements are different from the financial reports used to monitor and control budgetary resources which are prepared from the same books and records.

The statements should be read with the realization that they are prepared by an independent entity of the Federal government, that liabilities not covered by budgetary resources cannot be liquidated without the enactment of an appropriation and that the payment of all liabilities other than for contracts can be nullified by the entity.

Note 2: Fund Balance with Treasury: (Dollars in Millions)

Fund Balances	Obligated	Unobligated Available	Unobligated Restricted	Total
Trust Funds				
HI Trust Fund Balance	$52			$52
SMI Trust Fund Balance	5			5
Revolving Funds				
HMO Loan (1)	1	$8		9
CLIA (1)	10	9		19
Appropriated Funds				
Medicaid	4,904	5,229		10,133
Payments to the Health Care Trust Funds (1)			$3,967	3,967
Other Fund Types				
HCFA Suspense Account (1)		5		5
Total Fund Balance	**$4,972**	**$5,251**	**$3,967**	**$14,190**

(1) These funds balances are reported in the Supplemental Information Section under "All Others" on the Statement of Financial Position by Activity.

Note 3: Investments and Interest Receivable (Dollars in Millions)

	MATURITY RANGE	INTEREST RANGE	VALUE
HI			
Certificates	June 1994	5 5/8 - 5 7/8%	$1,160
Bonds	June 1994 to June 2008	6 1/4 - 13 3/4%	124,918
TOTAL HI INVESTMENTS			**$126,078**
SMI			
Certificates	June 1994	5 5/8 - 5 7/8%	$1,319
Bonds	June 1994 to June 2008	6 1/4 - 13 3/4%	21,949
TOTAL SMI INVESTMENTS			**$23,268**
TOTAL MEDICARE TRUST FUND INVESTMENTS			**$149,346**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicaid program expenses by the programs is the net amount outstanding reported in the Combined Statement of Financial Position. This schedule summarizes the nature and amount of investments in the Medicare trust funds. See Statement of Accounts for HI and SMI Trust Fund Investments for a detailed description of the holdings.

The Interest receivable is reported to HCFA by the U.S. Treasury and reflects the interest due the trust funds as of September 30, 1993 from the investments listed above.

Note 4: Accounts Receivable (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Accounts Receivable Governmental	$2,672	$1,468	$4,140	$85	$121	$4,346
Allowance for Uncollectible Accounts	707	405	1,112	17	7	1,136
NET GOVERNMENTAL RECEIVABLES	**$1,965**	**$1,063**	**$3,028**	**$68 ***	**$114**	**$3,210**

The accounts receivable were primarily reported from data received by the Medicare contractors. The majority of these receivables are due to overpayments to providers, beneficiaries, physicians and suppliers and to those claims where Medicare should be the secondary rather than the primary payer (Medicare Secondary Payer–MSP–claims). Only those MSP claims that have been identified to a debtor and a collectible amount has been determined are included in the accounts receivable. An additional 4 million claims are being researched as potential MSP accounts receivable and have not been reported due to the uncertain nature of the leads.

The majority of the allowance for uncollectible accounts came from Medicare contractors data based on the last five years (if available) of historical loss experience by type. The allowance was adjusted for those contractors that did not report historical loss experience. The balance of the allowance was reported by HCFA components as a result of an analysis of individual debtors and group analysis that included accounts receivable that were delinquent for more than one year and did not have payment activity within that year.

* May be further adjusted depending upon resolution of IG audit of State Medicaid Accounts Receivable.

Note 5: Accounts Payable

The $14,160 reported as accounts payable (Governmental) is an estimate by HCFA's Office of the Actuary (OACT) of Medicare services for which payment has not yet been drawn from the HI or SMI trust funds as of September 30, 1993. The estimates are based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. They include, for both the HI and SMI programs, (1) services that have been incurred and not yet billed to the Medicare contractors, (2) claims that have been submitted to the Medicare contractors but not yet approved for payment, (3) claims that have been approved but payment has not yet been made by the Medicare contractors and (4) checks issued in payment of a claim that have not been presented for payment and, therefore, funds have not yet been withdrawn from the HI or SMI trust funds. Due to the difficulty in determining the first estimate, services performed not yet billed, the payable must be developed using actuarial techniques. The same methodology used to develop the accounts payable is used to prepare the HI and SMI Annual Reports of the Boards of Trustees, all annual budget exercises including the President's Budget and Mid-Session Review and the annual development of the SMI premium.

The accounts payable does not include provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. The Board gets no information on the settlement amount for those appeals that are settled prior to a hearing. Therefore, the potential liability of these appeals is virtually impossible to predict.

As of September 30, 1993, there were 6,680 cases in appeal at the PRRB. Over 2,200 of these cases were filed in FY 1993. The PRRB rendered decisions on 105 cases in FY 1993 while approximately 2,200 additional cases were dismissed, withdrawn or settled prior to an appeal hearing.

Note 6: Other Unfunded Liabilities (Dollars in Millions)

	Medicaid
Medicaid Audit Disallowances Under Appeal	$8
Medicaid Program Disallowances Under Appeal	193
Medicaid Program Deferrals	333
Total Unfunded Liabilities	**$534**

Unfunded liabilities consist of contingent payables that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by States. In all cases, the funds have been returned to HCFA. Accordingly, HCFA will be required to pay these amounts if the appeals are decided in favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay about 45.5% of contingent payables. Therefore, of the total contingent payables of $534 million, HCFA will pay approximately $243 million.

Note 7: Net Position (Dollars in Millions)

BY PROGRAM	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Unexpended Appropriations:						
Unobligated						
Available	$118,572	$21,715	$140,287	$5,204	$8	$145,499
Unavailable					3,967	3,967
Undelivered Orders	597	290	887	7,366	20	8,273
Invested Capital	11	18	29	2		31
Other	12	35	47		114 (1)	161
Less: Future Funding Requirements	5	12	17	535		552 (2)
Total Net Position	**$119,187**	**$22,046**	**$141,233**	**$12,037**	**$4,109**	**$157,379**

BY FUND TYPE	Revolving Funds	Trust Funds	Approriated Funds	Combined Total
Unexpended Appropriations:				
Unobligated				
Available	$8	$140,287	$5,204	$145,499
Unavailable			3,967	3,967
Undelivered Orders	20	887	7,366	8,273
Invested Capital		29	2	31
Other	114 (1)	47		161
Less: Future Funding Requirements		17	535	552 (2)
Total Net Position	**$142**	**$141,233**	**$16,004**	**$157,379**

(1)This amount includes uncollected revenue for fines, penalties and interest that will be deposited to the general funds of the Federal government when collected.
(2)Future funding will be required to pay the current year accrual for annual leave that has been allocated to the trust funds and Medicaid and, for the current year contingent liabilities (audit/program disallowances and deferrals) of the Medicaid program.

Note 8: Employment Tax Revenue (Dollars in Millions)

In calendar year 1993, all employees and employers were required to contribute 1.45 percent of the first $135,000 of employees' wages to the Federal Medicare Hospital Insurance (HI) Trust Fund. In calendar year 1994, the salary limitation will be lifted and all wages will be subject to a 1.45 percent Medicare tax from both the employee and employer.

The Social Security Act requires the transfer of these contributions from the General Fund of the U.S. Treasury to the HI Trust Fund based on certified wages (reported via Form W-2) established and maintained by the Secretary of Health and Human Services. However, since tax year 1978, the Social Security Administration (SSA) has used the generally higher wage totals reported by employers via the quarterly Internal Revenue Service's (IRS) Form 941 (in lieu of Form W-2) as the basis for conducting an interim certification of regular wages. SSA is currently seeking congressional action to amend the Social Security Act to allow for the use of IRS' Form 941 to perform a final certification. This matter is discussed further in SSA's FY 1993 Annual Financial Statement.

Employment tax revenues are adjusted by excess contributions collected that are refunded to employees. FY 1993 HI Trust Fund employment tax revenue and refunds as reported by the U.S. Treasury are listed below.

Employment Tax Revenue	$83,151
Less Refunds	13
Employment Tax Revenue, Net	$83,138

Note 9: SMI Premiums Collected and Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and matched by the Federal government. The Omnibus Budget Reconciliation Act of 1990 set specific monthly premium levels for five calendar years beginning in 1991. The monthly premium in calendar year 1993 was $36.60 and covered approximately 26 percent of the SMI program's estimated 1993 costs. Premiums collected from beneficiaries totalled $14.7 billion in FY 1993 and were matched by a $44.2 billion contribution from the Federal government. This represents a Federal match of approximately $3 to every $1 collected in premiums.

Note 10: Other Revenue and Financing Sources (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	All Others	Combined Total
Premiums-Uninsured Individuals	$622		$622		$622
Transfer-Uninsured Coverage	485		485		485
Military Service Contribution	81		81		81
Interest				$74	74
Freedom of Information Act and Sale of Publications				45	45
Principal Payments				15	15
Income Tax Credit Reimbursement	10		10		10
Civil Monetary Penalties				6	6
Gifts and Miscellaneous	1	$1	2		2
Deposits By States	(1)		(1)		(1)
Total Other Revenue	**$1,198**	**$1**	**$1,199**	**$140**	**$1,339**

Note 11: Program or Operating Expenses by Object Class (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Program Expenses by Object Class:						
Insurance Claims and Indemnities	$87,756	$47,925	$135,681			$135,681
Grants, Subsidies and Contributions				$74,189		74,189
Operating Expenses by Object Class:						
Personal Services and Benefits	63	159	222	17	$4	243
Travel and Transportation	49	123	172	12		184
Rental, Communication and Utilities	5	12	17	1		18
Printing and Reproduction	1	4	5			5
Contractual Services	718	1,422	2,140	109	22	2,271
Supplies and Materials	1	1	2			2
Total Expenses by Object Class	**$88,593**	**$49,646**	**$138,239**	**$74,328**	**$26**	**$212,593**

Note 12: Administrative Expenses (Dollars in Millions)

MEDICARE	
Hospital Insurance	
U.S. Department of Treasury	$54
Social Security Administration (SSA)	384
Health Care Financing Administration	548
Office of the Secretary - DHHS	18
Payment Assessment Commission	4
Railroad Retirement Commission	(381)
Policy and Research	4
Peer Review Organizations	206
TOTAL HI ADMINISTRATIVE EXPENSE	**$837**
Supplementary Medical Insurance	
U.S. Department of Treasury	$7
Social Security Administration (SSA)	295
Health Care Financing Administration	1,390
Office of the Secretary - DHHS	14
Physicians Payment Review Commission	5
Policy and Research	2
Peer Review Organizations	8
TOTAL SMI ADMINISTRATIVE EXPENSE	**$1,721**
TOTAL MEDICARE TRUST FUND ADMINISTRATIVE EXPENSE	**$2,558**
MEDICAID	
Health Care Financing Administration	$139
TOTAL ADMINISTRATIVE EXPENSES	**$2,697**

For purposes of financial statement presentation, administrative costs are considered expensed to the Medicare trust funds when outlayed by the U.S. Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the Social Security Administration (SSA) reported $81 million of Property and Equipment, (Net) attributable to the Medicare program as of September 30, 1993. This amount is not included in HCFA's Combined Statement of Financial Position as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 1993 to pay for this activity are included in this section as an administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by the U.S. Treasury. These expenses are also reported by SSA on their FY 1993 Annual Financial Statement.

HCFA's administrative costs have been allocated to the Medicare and Medicaid programs based on the HCFA cost allocation system. Administrative costs allocated to the Medicare program include $1.5 billion paid to Medicare contractors to carry out their responsibilities as HCFA's agents in the administration of the Medicare program.

Note 13: Unfunded Expenses (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Fiscal Year 1993 Contingent Liabilities						
Medicare Claims Under Appeal (Contingent)	($17)	($159)	($176)			($176)
Program Deferrals (Contingent)				($325)		(325)
Program Disallowances Under Appeal (Contingent)				(1,120)		(1,120)
Audit Disallowances Under Appeal (Contingent)				(79)		(79)
Accrued Leave					($1)	(1)
Total Unfunded Expenses	**($17)**	**($159)**	**($176)**	**($1,524)**	**($1)**	**($1,701)**

Medicare claims under appeal, Medicaid audit and program disallowances under appeal, and Medicaid deferrals are classified as unfunded contingent liabilities. As discussed in Note 6, Other Unfunded Liabilities, these amounts will be paid if the appeals are decided in favor of the claimant and additional data is provided to support the legitimacy of a Medicaid expenditure claim. Negative amounts are shown because more contingent liabilities established in prior fiscal years were settled during FY 1993 than new contingencies recognized.

Note 14: Non-Operating Changes (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Equipment Transferred In	$4		$4			$4
Equipment Transferred Out	(1)	($3)	(4)			(4)
Loan Payments to FFB Exceeded Collections from HMO Recipients					$11	11
Current Year Warrants Exceeding Appropriated Capital Used				$8,406	1,252	9,658
TOTAL NON-OPERATING CHANGES	**$3**	**($3)**		**$8,406**	**$1,263**	**$9,669**

Supplemental Information

TOTAL OUTLAYS

	FY 1991	FY 1992	FY 1993
Dollars in Millions)			
Medicare Benefits:			
HI	$68,486	$80,584	$90,535
SMI	45,456	48,596	52,398
Total	$113,942	$129,180	$142,933
Medicaid Grants to States			
Medical Assistance Payments	$50,179	$65,359	$72,791
State & Local Administration	2,354	2,468	2,983
Total	$52,533	$67,827	$75,774
Administration			
Program Management	$1,923	$2,117	$2,044
Peer Review Organization	277	232	214
Social Security Administration	558	662	680
Other Non-HCFA Federal	86	87	108
CLIA	.....	4	21
Total	$2,844	$3,102	$3,067
Total Program Outlays	$169,319	$200,109	$221,774

TOTAL ENROLLEES

	FY 1991	FY 1992	FY 1993
(Persons in Millions)			
Medicare	34.7	35.4	36.1
Medicaid	28.3	30.9	33.4
Total	63.0	66.3	69.5

Total includes persons enrolled in both programs.

MEDICARE BENEFIT OUTLAYS

	FY 1991	FY 1992	FY 1993
(Dollars in Millions)			
HI:			
Inpatient Hospital	$60,491	$69,145	$75,021
Skilled Nursing Facility	4,995	3,645	5,027
Home Health	2,512	6,986	9,529
Hospice	465	808	958
Total	$68,463	$80,584	$90,535
SMI:			
Physician	$31,127	$32,304	$33,800
Outpatient	9,234	10,671	11,916
Group Practice	3,411	3,810	4,550
Independent Laboratory	1,680	1,735	2,031
Other	64	75	101
Total	45,516	48,595	52,398
Total Benefit Outlays	$113,979	$129,179	$142,933

MEDICARE ENROLLEES

	FY 1991	FY 1992	FY 1993
(Persons in Millions)			
HI:			
Aged	30.5	30.8	31.6
Disabled	3.4	3.6	3.8
Total	33.9	34.4	35.4
SMI:			
Aged	29.9	30.5	31.0
Disabled	3.0	3.1	3.3
Total	32.9	33.6	34.3

HOSPITAL INSURANCE TRUST FUND PROJECTIONS (Dollars in Billions)

Calendar Year	Total Income	Total Disbursements	Net Increase in Fund	Fund at End of Year	Ratio: Assets to Disbursements
1992	$93.8	$85.0	$8.8	$124.0	136
1993	97.6	94.1	3.5	127.5	132
1994	103.2	105.8	(2.6)	124.9	120
1995	107.4	117.9	(10.5)	114.4	106
1996	111.4	131.3	(19.9)	94.5	87
1997	114.4	143.6	(29.2)	65.3	66
1998	117.5	156.6	(39.1)	26.2	42
1999	120.5	170.9	(50.4)	(4.0)	15

Reflects intermediate actuarial assumptions of the 1993 Annual Report of the Trustees of the HI Trust Fund.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND PROJECTIONS (Dollars in Billions)

Calendar Year	Enrollee Premiums	Other Income	Total Income	Total Disbursements	Fund at End of Year
1992	$14.1	$43.2	$57.3	$50.8	$24.2
1993	14.0	40.9	54.9	56.9	22.3
1994	17.3	45.3	62.6	65.6	19.3
1995	19.8	53.0	72.8	75.9	16.2
1996	20.7	62.8	83.5	86.5	13.1
1997	21.7	77.4	99.1	97.8	14.5
1998	22.7	89.1	111.8	110.3	15.9
1999	23.8	102.2	126.0	124.4	17.5
2000	24.9	117.5	142.4	140.6	19.3
2001	26.2	135.1	161.3	159.2	21.4
2002	27.5	155.2	182.7	180.4	23.8

Reflects intermediate actuarial assumptions of the 1993 Annual Report of the Trustees of the SMI Trust Fund.

MEDICARE PEER REVIEW ORGANIZATION COSTS

	FY 1991	FY 1992	FY 1993
(Dollars in Millions)			
Obligations	$129	$188	$475
Outlays	$277	$232	$214

SELECTED MEDICARE INDICATORS

	FY 1991	FY 1992	FY 1993
Hospital Admissions	10.4 million	11.1 million	11.2 million
Benefits per Admission	$5,869	$6,441	$6,747
SNF Days per Enrollee	0.7	0.8	0.9
SNF Benefits per Day	$103	$142	$171
HHA Visits per Enrollee	2.2	3.7	4.7
HHA Benefits per Visit	$69	$59	$61

MEDICAID OUTLAYS

	FY 1991	FY 1992	FY 1993
(Dollars in Millions)			
Federal Outlays:			
Medical Assistance	$50,179	$65,359	$72,791
Administration	2,354	2,468	2,983
Total Federal	$52,533	$67,827	$75,774
State Outlays:			
Medical Assistance	$40,269	$48,466	$53,802
Administration	1,723	1,873	2,199
Total State	$41,992	$50,339	$56,001
Total Outlays	$94,525	$118,166	$131,775

MEDICAID MEDICAL ASSISTANCE BY SERVICE

	FY 1991	FY 1992	FY 1993
(Dollars in Billions)			
Inpatient Hospital	25.7	37.5	39.6
Mental Health Facility	2.3	4.9	5.0
Nursing Facility	20.8	24.4	26.1
ICF/MR	8.2	8.7	9.3
Prescription Drugs	5.6	6.2	6.9
Physician	5.4	6.7	7.4
Health Insurance	4.5	5.7	7.8
Outpatient Hospital	4.3	5.5	6.3
Home Health/Personal Care	3.2	3.6	3.9
Clinic	1.7	2.3	2.7
Other	8.8	10.3	10.8
Total Expenditures	90.5	115.9	125.8
Total Outlays	94.5	118.2	131.8

MEDICAID ENROLLEES

	FY 1991	FY 1992	FY 1993
(Persons in Millions)			
Needy Adults	6.8	7.0	7.5
Needy Children	13.4	15.1	16.3
Disabled	4.1	4.5	5.0
Elderly	3.4	3.7	3.9
Other	0.7	0.7	0.7
Total	28.3	30.9	33.4

HCFA PROGRAM MANAGEMENT OUTLAYS

	FY 1991	FY 1992	FY 1993
(Dollars in Millions)			
Research	$14	$59	$69
Medicare Contractors	1,428	1,502	1,503
State Certification	121	134	136
Administrative Costs	233	323	335
Adjustments	4	79	.....
Total Outlays	$1,800	$2,096	$2,044

MEDICARE PAYMENT SAFEGUARDS

	FY 1991	FY 1992	FY 1993
(Dollars in Millions)			
Investments (outlays)	$361	$351	$406
Savings:			
Medicare Secondary Payer	$2,639	$2,810	$3,135
Provider Audit	1,701	974	1,711
Medical & Utilization Review	1,459	1,382	1,400
Total Savings	$5,799	$5,166	$6,246

MEDICARE CLAIMS PROCESSING MEASURES

	FY 1991	FY 1992	FY 1993
Claims Submitted Electronically:			
Part A	76%	81%	88%
Part B	41%	50%	61%
Claims Processing Backlog (as Percent of Total Claims):			
Part A	2%	2%	2%
Part B	3%	2%	2%
Processing Unit Costs:			
Part A	$3.00	$2.78	$2.61
Part B	$1.86	$1.71	$1.60

MEDICARE STATE CERTIFICATION, FY 1993

	Facilities	Surveys	Coverage
SNF (Medicare only)	938	934	100%
SNF (Medicare/Medicaid)	10,507	10,604	101%
Hospital (Non-Accredited)	1,351	597	44%
Hospital (Accredited)	5,067	2,098	41%
Home Health Agency	6,993	6,402	92%
ESRD Facility	2,448	1,535	63%
Hospice	1,382	652	47%
Mammography	6,874	3,004	44%
Other	5,278	2,518	48%
Total	40,838	28,344	69%

MEDICARE STATE CERTIFICATION MEASURES

	FY 1991	FY 1992	FY 1993
Facilities Cited for Deficiencies:			
Condition-Level Deficiencies	1,802	1,638	1,876
Standard-Level Deficiencies	15,752	18,087	18,399
As Percent of Facilities Surveyed:			
Condition-Level Deficiencies	7%	6%	7%
Standard-Level Deficiencies	58%	65%	65%

Research and Demonstrations

The goal of HCFA's research, demonstration, and evaluation program is to provide timely, reliable information required for informed and rational decision-making in the Medicare and Medicaid programs.

This goal was pursued through seven primary objectives:

1. To improve access and quality of care for Medicare and Medicaid beneficiaries.

2. To increase health service delivery options for consumers.

3. To further refine existing payment systems for hospital, physician, and outpatient care.

4. To increase understanding of the problems of health care access and financing in the United States and to evaluate promising systems and financing alternatives.

5. To increase understanding of how the health care market has responded to changes in the Medicare and Medicaid programs.

6. To assess how quality health services should be efficiently and effectively delivered.

7. To better understand trends and factors affecting cost, accessibility, and quality of subacute and long-term care under Medicare and Medicaid.

HCFA made significant strides toward fulfilling its primary research objectives. Major accomplishments included:

- Medicaid reform demonstrations in Oregon, Hawaii, Kentucky, Rhode Island, and Tennessee were initiated.

- A series of research projects was initiated in support of national health care reform.

- Research on an outcome-based quality assurance system for home health agencies was conducted. This research formed the basis for activities related to revising the quality assurance model for HHAs.

- Research and demonstrations continued in developing and refining methods of assuring quality of care to nursing home residents.

- Further research was conducted to determine the impact on beneficiary access of the Medicare Fee Schedule for physicians.

- Two demonstrations resulted in inclusion in the Medicare program of two prevention benefits: therapeutic shoes for beneficiaries with diabetic foot disease, and influenza vaccine.

- Development of an outpatient classification system (APGs) continued.

- Development and refinement of an alternative nursing home resident assessment and care planning tool (MDS+) continued. This alternative form has been approved for use in nine States and has been adopted for use by the Department of Veterans Affairs.

The HCFA Office of Research and Demonstrations funded 174 extramural research projects, including 79 new projects and 95 continued from previous years. HCFA also issued 551 grants under two major grant programs. Obligations totaled $68.2 million, of which $36.6 million was devoted to the on-going research program and $32.6 million to Congressional grant programs. $18.5 million was spent on Medicaid research, $17.1 million on Medicare research.

Grant activity included the Rural Health Transition Program, totally $22.7 million in grants to 498 hospitals; and Insurance Counseling Grants, totaling $9.9 million awared to the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

Federal Managers' Financial Integrity Act

In FY 1993, HCFA was successful in clearing up one High Risk Area, Medicaid Program Data, and four material weaknesses.

High Risk Area Cleared

Medicaid Program Data. To meet concerns that Medicaid estimates were inaccurate, new information and collection forms were developed and implemented. The new Medicaid Program Budget Report Form provides a schedule for States and HCFA personnel to report and explain items which may have a significant budget impact, such as State legislation, court cases, and other program influences.

Material Weaknesses Cleared

The Medicaid Eligibility Quality Control (MEQC) Program. HCFA has closed this material weakness since the corrective action requires legislation. State interest in legislation does not exist currently, and Federal interest in legislation is limited due to the impending health care reform.

Paperwork Reduction Act. HCFA has implemented controls to assure the collection of information meets statutory requirements. The backlog has been cleared up and this process should eliminate the recurrence of the problem.

Medicare Credit Balances. HCFA has developed mandatory credit balance reporting to ensure that Medicare hospitals and other health care providers make adequate provisions to refund any monies incorrectly paid due to provider billing practices.

Separately Billable Drug and Blood Services Under the End Stage Renal Disease (ESRD) Program. HCFA has developed fee schedules and manual instructions to advise Medicare intermediaries that they must pay independent dialysis facilities for separately billable drugs and blood services based on a reasonable payment amount rather than as billed.

Current FMFIA Issues

Although HCFA is in compliance with the FMFIA, there is one "high risk area" (HRA) requiring improvement, seven MWs pending from prior years, and one new MW, Medicare Accounts Receivable. In response to concerns that Medicare contractors were not adequately covered by internal controls, an effort was made to identify oversight programs which review the contractors' activities. This analysis resulted in the identification of over 5,000 alternative reviews of its Medicare contractors conducted by HCFA during FY 1993. To maximize this effort, a work group has been formed to review controls identified to ensure all areas are appropriately covered.

High Risk Area

Medicare Secondary Payer (MSP). It is estimated that the Medicare program may pay out as much as $400 million a year unnecessarily because Medicare fiscal intermediaries and carriers do not always identify the primary payers; and because insurers, underwriters, and third party administrators often do not pay as primary payers when they are so required. Over the last several years, HCFA has actively pursued several initiatives, including legislative proposals, the filing of lawsuits against noncomplying insurers, and data matches with the Social Security Administration (SSA) and the Internal Revenue Service (IRS) to improve the MSP program. Savings for FY 1993 were $2.8 billion. The return on investment is impressive: for every $1 spent on administrative (including recovery) costs, $35 was saved.

Ongoing activity will focus on (1) preventing inappropriate primary payments by Medicare through implementation of the initial enrollment questionnaire (IEQ) for beneficiaries, (2) managing the backlog of recoveries, and (3) developing an improved reporting mechanism for accounts receivable.

Material Weaknesses

Funding Payment Safeguards. Inadequate and/or fluctuating program funding for payment safeguards has prevented Medicare contractors from maintaining adequate, well-trained, and seasoned staff to perform the payment safeguard functions in accordance with program guidelines. A legislative proposal was submitted to OMB in FY 1993 that would establish a self-financing revolving fund for Medicare payment safeguards.

Payments for Medically Unnecessary Services. HCFA has taken steps to require carriers to detect aberrant ordering/referring patterns and make educational contacts with the physician. In addition, HCFA is in the process of implementing regional processing of DME claims to permit greater specialization in this area.

Indirect Medical Education (IME). Some Medicare hospitals were overpaid for IME because HCFA did not have a record of the interns and residents that worked at VA and DOD hospitals in its computer matching data base, and some duplications were not detected. HCFA is coordinating data exchanges with VA and DOD to resolve this problem.

Grants Management . HCFA is taking action to improve controls over the grants management process and the acquisition of research and development services. This material weakness will be kept open pending a review by the Logistics Management Institute.

Office of Budget and Administration (OBA) Procurement. The Office of Acquisition and Grants could not ensure sufficient controls on procurement activities, adherence to procurement rules and regulations, and advance planning of procurements. All major corrective actions have been completed, but the material weakness is being kept open pending a review by the Logistics Management Institute.

Medicare Contractor Accounts Receivable. Some contractor financial management systems failed to properly record, monitor and follow-up all accounts receivable data. HCFA is currently in the process of developing a corrective action plan.

Failure to Meet Statutory Deadlines for Responses to Freedom of Information Act (FOIA) Requests. HCFA is unable to meet the FOIA requirement that agencies must provide a substantive response to requesters within ten working days. A number of actions have been taken, including restructuring FOIA management. A review of this area is being made to determine if there are any additional actions available given the current resources.

STATEMENT OF ACCOUNT FOR HI TRUST FUND INVESTMENTS
DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1993

U.S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
5-7/8% maturing June 30, 1994	$6,662,745,000	$6,662,745,000	$0
5-7/8% maturing June 30, 1994	$7,330,700,000	$7,330,700,000	$0
5-5/8% maturing June 30, 1994	$8,027,996,000	$6,867,609,000	$1,160,387,000
Total Certificates of Indebtedness	$22,021,441,000	$20,861,054,000	$1,160,387,000

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-3/4% due June 30, 1999	$850,544,000	$0	$850,544,000
13-3/4% due June 30, 1998	$262,134,000	$0	$262,134,000
13-1/4% due June 30, 1997	$1,450,129,000	$0	$1,450,129,000
13-1/4% due June 30, 1996	$272,853,000	$0	$272,853,000
13-1/4% due June 30, 1995	$272,853,000	$0	$272,853,000
13-1/4% due June 30, 1994	$272,853,000	$0	$272,853,000
13% due June 30, 1996	$1,177,276,000	$0	$1,177,276,000
13% due June 30, 1995	$197,606,000	$0	$197,606,000
13% due June 30, 1994	$197,606,000	$0	$197,606,000
10-3/4% due June 30, 1998	$588,410,000	$0	$588,410,000
10-3/8% due June 30, 2000	$1,277,566,000	$0	$1,277,566,000
10-3/8% due June 30, 1999	$427,022,000	$0	$427,022,000
10-3/8% due June 30, 1998	$427,022,000	$0	$427,022,000
9-3/4% due June 30, 1995	$979,670,000	$0	$979,670,000
9-3/4% due June 30, 1994	$130,210,000	$0	$130,210,000
9-1/4% due June 30, 2003	$4,229,944,000	$0	$4,229,944,000
9-1/4% due June 30, 2002	$1,034,542,000	$0	$1,034,542,000
9-1/4% due June 30, 2001	$1,034,542,000	$0	$1,034,542,000
9-1/4% due June 30, 2000	$1,034,542,000	$0	$1,034,542,000
9-1/4% due June 30, 1999	$1,034,542,000	$0	$1,034,542,000
9-1/4% due June 30, 1998	$1,034,541,000	$0	$1,034,541,000
9-1/4% due June 30, 1997	$1,034,541,000	$0	$1,034,541,000
9-1/4% due June 30, 1996	$1,034,541,000	$0	$1,034,541,000
9-1/4% due June 30, 1995	$1,034,541,000	$0	$1,034,541,000
9-1/4% due June 30, 1994	$1,034,541,000	$0	$1,034,541,000
8-3/4% due June 30, 2005	$6,415,695,000	$0	$6,415,695,000
8-3/4% due June 30, 2004	$6,415,695,000	$0	$6,415,695,000
8-3/4% due June 30, 2003	$2,185,751,000	$0	$2,185,751,000
8-3/4% due June 30, 2002	$2,185,751,000	$0	$2,185,751,000
8-3/4% due June 30, 2001	$2,185,751,000	$0	$2,185,751,000
8-3/4% due June 30, 2000	$2,185,751,000	$0	$2,185,751,000
8-3/4% due June 30, 1999	$2,185,751,000	$0	$2,185,751,000
8-3/4% due June 30, 1998	$2,185,752,000	$0	$2,185,752,000
8-3/4% due June 30, 1997	$2,185,752,000	$0	$2,185,752,000
8-3/4% due June 30, 1996	$2,185,752,000	$0	$2,185,752,000
8-3/4% due June 30, 1995	$2,185,752,000	$0	$2,185,752,000

STATEMENT OF ACCOUNT FOR HI TRUST FUND INVESTMENTS

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
8-3/4% due June 30, 1994	$3,035,212,000	$0	$3,035,212,000
8-5/8% due June 30, 2002	$3,195,402,000	$0	$3,195,402,000
8-5/8% due June 30, 2001	$686,250,000	$0	$686,250,000
8-5/8% due June 30, 2000	$686,250,000	$0	$686,250,000
8-5/8% due June 30, 1999	$686,250,000	$0	$686,250,00
8-5/8% due June 30, 1998	$686,251,000	$0	$686,251,000
8-5/8% due June 30, 1997	$686,251,000	$0	$686,251,000
8-5/8% due June 30, 1996	$686,250,000	$0	$686,250,000
8-5/8% due June 30, 1995	$686,250,000	$0	$686,250,000
8-5/8% due June 30, 1994	$686,250,000	$112,459,000	$573,791,000
8-3/8% due June 30, 2001	$2,509,152,000	$0	$2,509,152,000
8-3/8% due June 30, 2000	$1,231,586,000	$0	$1,231,586,000
8-3/8% due June 30, 1999	$1,231,586,000	$0	$1,231,586,000
8-3/8% due June 30, 1998	$1,231,586,000	$0	$1,231,586,000
8-3/8% due June 30, 1997	$1,059,023,000	$0	$1,059,023,000
8-3/8% due June 30, 1996	$1,059,024,000	$0	$1,059,024,000
8-3/8% due June 30, 1995	$1,059,024,000	$0	$1,059,024,000
8-3/8% due June 30, 1994	$1,059,024,000	$1,059,024,000	$0
8-1/8% due June 30, 2006	$7,316,968,000	$0	$7,316,968,000
8-1/8% due June 30, 2005	$901,273,000	$0	$901,273,000
8-1/8% due June 30, 2004	$901,273,000	$0	$901,273,000
8-1/8% due June 30, 2003	$901,273,000	$0	$901,273,000
8-1/8% due June 30, 2002	$901,274,000	$0	$901,274,000
8-1/8% due June 30, 2001	$901,274,000	$0	$901,274,000
8-1/8% due June 30, 2000	$901,274,000	$0	$901,274,000
8-1/8% due June 30, 1999	$901,274,000	$0	$901,274,000
8-1/8% due June 30, 1998	$901,273,000	$0	$901,273,000
8-1/8% due June 30, 1997	$901,273,000	$0	$901,273,000
8-1/8% due June 30, 1996	$901,273,000	$0	$901,273,000
8-1/8% due June 30, 1995	$901,273,000	$0	$901,273,000
8-1/8% due June 30, 1994	$901,273,000	$901,273,000	$0
7-3/8% due June 30, 2007	$8,184,929,000	$0	$8,184,929,000
7-3/8% due June 30, 2006	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 2005	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 2004	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 2003	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 2002	$867,960,000	$0	$867,960,000
7-3/8% due June 30, 2001	$867,960,000	$0	$867,960,000
7-3/8% due June 30, 2000	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 1999	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 1998	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 1997	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 1996	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 1995	$867,961,000	$0	$867,961,000
7-3/8% due June 30, 1994	$867,961,000	$867,961,000	$0

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6-1/4% due June 30, 1994	$363,197,000	$363,197,000	$0
6-1/4% due June 30, 1995	$363,197,000	$0	$363,197,000
6-1/4% due June 30, 1996	$363,197,000	$0	$363,197,000
6-1/4% due June 30, 1997	$363,197,000	$0	$363,197,000
6-1/4% due June 30, 1998	$363,197,000	$0	$363,197,000
6-1/4% due June 30, 1999	$363,197,000	$0	$363,197,000
6-1/4% due June 30, 2000	$363,197,000	$0	$363,197,000
6-1/4% due June 30, 2001	$363,198,000	$0	$363,198,000
6-1/4% due June 30, 2002	$363,198,000	$0	$363,198,000
6-1/4% due June 30, 2003	$363,198,000	$0	$363,198,000
6-1/4% due June 30, 2004	$363,198,000	$0	$363,198,000
6-1/4% due June 30, 2005	$363,198,000	$0	$363,198,000
6-1/4% due June 30, 2006	$363,198,000	$0	$363,198,000
6-1/4% due June 30, 2007	$363,197,000	$0	$363,197,000
6-1/4% due June 30, 2008	$8,548,126,000	$0	$8,548,126,000
Total Bonds	**$128,221,903,000**	**$3,303,914,000**	**$124,917,989,000**
Total U.S. Treasury Special Issues	**$150,243,344,000**	**$24,164,968,000**	**$126,078,376,000**

SOURCE:
DEPARTMENT OF THE TREASURY
FINANCIAL MANAGEMENT SERVICE

FUNDS MANAGEMENT DIVISION
FUNDS ACCOUNTING BRANCH

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS

U.S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
5-7/8% maturing June 30, 1994	$4,980,108,000	$4,980,108,000	$0
5-7/8% maturing June 30, 1994	$5,047,946,000	$4,958,980,000	$88,966,000
5-5/8% maturing June 30, 1994	$5,237,946,000	$4,008,236,000	$1,229,710,000
Total Certificates of Indebtedness	$15,266,000,000	$13,947,324,000	$1,318,676,000

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-3/4% due June 30, 1999	$567,103,000	$0	$567,103,000
13-3/4% due June 30, 1998	$110,114,000	$0	$110,114,000
13-3/4% due June 30, 1997	$110,115,000	$0	$110,115,000
13-3/4% due June 30, 1996	$110,115,000	$0	$110,115,000
13-3/4% due June 30, 1995	$110,115,000	$0	$110,115,000
13-3/4% due June 30, 1994	$110,115,000	$0	$110,115,000

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-1/4% due June 30, 1997	$368,928,000	$0	$368,928,000
13-1/4% due June 30, 1996	$368,928,000	$0	$368,928,000
13-1/4% due June 30, 1995	$253,926,000	$0	$253,926,000
13-1/4% due June 30, 1994	$42,201,000	$0	$42,201,000
10-3/4% due June 30, 1998	$456,989,000	$0	$456,989,000
10-3/4% due June 30, 1997	$88,061,000	$0	$88,061,000
10-3/4% due June 30, 1996	$88,061,000	$0	$88,061,000
10-3/4% due June 30, 1995	$88,060,000	$0	$88,060,000
10-3/4% due June 30, 1994	$88,060,000	$0	$88,060,000
10-3/8% due June 30, 2000	$733,187,000	$0	$733,187,000
10-3/8% due June 30, 1999	$166,084,000	$0	$166,084,000
10-3/8% due June 30, 1998	$166,084,000	$0	$166,084,000
10-3/8% due June 30, 1997	$166,083,000	$0	$166,083,000
10-3/8% due June 30, 1996	$166,083,000	$0	$166,083,000
10-3/8% due June 30, 1995	$166,083,000	$0	$166,083,000
10-3/8% due June 30, 1994	$97,688,000	$0	$97,688,000
9-3/4% due June 30, 1995	$115,003,000	$0	$115,003,000
8-3/4% due June 30, 2005	$991,433,000	$0	$991,433,000
8-3/4% due June 30, 2004	$991,433,000	$0	$991,433,000
8-3/4% due June 30, 2003	$991,433,000	$0	$991,433,000
8-3/4% due June 30, 2002	$991,433,000	$0	$991,433,000
8-3/4% due June 30, 2001	$547,163,000	$0	$547,163,000
8-3/4% due June 30, 2000	$258,246,000	$0	$258,246,000
8-3/4% due June 30, 1999	$258,246,000	$0	$258,246,000
8-3/4% due June 30, 1998	$258,247,000	$0	$258,247,000
8-3/4% due June 30, 1997	$258,247,000	$0	$258,247,000
8-3/4% due June 30, 1996	$258,247,000	$0	$258,247,000
8-3/4% due June 30, 1995	$258,247,000	$0	$258,247,000
8-3/4% due June 30, 1994	$398,322,000	$114,333,000	$283,989,000
8-3/8% due June 30, 2001	$444,270,000	$0	$444,270,000
8-1/8% due June 30, 2006	$1,218,813,000	$0	$1,218,813,000
8-1/8% due June 30, 2005	$227,380,000	$0	$227,380,000
8-1/8% due June 30, 2004	$227,381,000	$0	$227,381,000
8-1/8% due June 30, 2003	$227,381,000	$0	$227,381,000
8-1/8% due June 30, 2002	$227,381,000	$0	$227,381,000
8-1/8% due June 30, 2001	$227,381,000	$0	$227,381,000
8-1/8% due June 30, 2000	$227,381,000	$0	$227,381,000
8-1/8% due June 30, 1999	$227,381,000	$0	$227,381,000
8-1/8% due June 30, 1998	$227,380,000	$0	$227,380,000
8-1/8% due June 30, 1997	$227,380,000	$0	$227,380,000
8-1/8% due June 30, 1996	$227,380,000	$0	$227,380,000
8-1/8% due June 30, 1995	$227,380,000	$0	$227,380,000
7-3/8% due June 30, 2007	$1,293,107,000	$0	$1,293,107,000
7-3/8% due June 30, 2006	$74,295,000	$0	$74,295,000
7-3/8% due June 30, 2005	$74,295,000	$0	$74,295,000
7-3/8% due June 30, 2004	$74,294,000	$0	$74,294,000

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-3/8% due June 30, 2003	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 2002	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 2001	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 2000	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 1999	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 1998	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 1997	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 1996	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 1995	$74,294,000	$0	$74,294,000
7-3/8% due June 30, 1994	$556,722,000	$556,722,000	$0
6-1/4% due June 30, 1994	$744,393,000	$744,393,000	$0
6-1/4% due June 30, 1995	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 1996	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 1997	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 1998	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 1999	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2000	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2001	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2002	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2003	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2004	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2005	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2006	$230,256,000	$0	$230,256,000
6-1/4% due June 30, 2007	$230,257,000	$0	$230,257,000
6-1/4% due June 30, 2008	$1,523,363,000	$0	$1,523,363,000
Total Bonds	**$23,364,596,000**	**$1,415,448,000**	**$21,949,148,000**
Total U.S. Treasury Special Issues	**$38,630,596,000**	**$15,362,772,000**	**$23,267,824,000**

SOURCE:
DEPARTMENT OF THE TREASURY
FINANCIAL MANAGEMENT SERVICE
FUNDS MANAGEMENT DIVISION
FUNDS ACCOUNTING BRANCH

STATEMENT OF FINANCIAL POSITION BY ACTIVITY
AS OF SEPTEMBER 30, 1993

	(Dollars in Millions)					
	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
ASSETS						
Financial Resources:						
Intragovernmental Items:						
Fund Balances	$52	$5	$57	$10,133	$4,000	$14,190
Interest Receivable	2,635	478	3,113			3,113
Investments	126,078	23,268	149,346			149,346
Governmental Items:						
Accounts Receivable, Net	1,965	1,063	3,028	68	114	3,210
Loans Receivable, Net					23	23
Total Financial Resources:	**$130,730**	**$24,814**	**$155,544**	**$10,201**	**$4,137**	**$169,882**
Non-Financial Resources:						
Governmental:						
Advances and Prepayments	$11	$19	$30	$2,370	$11	$2,411
Property and Equipment, Net	11	18	29	2		31
Total Non-Financial Resources:	**$22**	**$37**	**$59**	**$2,372**	**$11**	**$2,442**
TOTAL ASSETS	**$130,752**	**$24,851**	**$155,603**	**$12,573**	**$4,148**	**$172,324**

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
LIABILITIES						
Funded Liabilities:						
Intragovernmental:						
Accounts Payable	$1	$3	$4	$1		$5
Suspense Account Deposit Funds					$4	4
Governmental:						
Accounts Payable	11,510	2,650	14,160			14,160
Accrued Payroll and Benefits	1	4	5			5
Liabilities For Loan Guarantees					34	34
Deferred Revenue	48	136	184			184
Accrued Interest Payable					1	1
Total Funded Liabilities	**$11,560**	**$2,793**	**$14,353**	**$1**	**$39**	**$14,393**
Unfunded Liabilities:						
Governmental:						
Accrued Leave	$5	$12	$17	$1		$18
Other Unfunded Liabilities				534		534
Total Unfunded Liabilities	**$5**	**$12**	**$17**	**$535**		**$552**
TOTAL LIABILITIES	**$11,565**	**$2,805**	**$14,370**	**$536**	**$39**	**$14,945**
NET POSITION						
Fund Balances:						
Unexpended Appropriations	$119,169	$22,005	$141,174	$12,570	$3,995	$157,739
Invested Capital	11	18	29	2		31
Other	12	35	47		114	161
Less: Future Funding Requirements	5	12	17	535		552
TOTAL NET POSITION	**$119,187**	**$22,046**	**$141,233**	**$12,037**	**$4,109**	**$157,379**
TOTAL LIABILITIES & NET POSITION	**$130,752**	**$24,851**	**$155,603**	**$12,573**	**$4,148**	**$172,324**

STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION BY ACTIVITY
FOR THE PERIOD ENDED SEPTEMBER 30, 1993

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
REVENUE AND FINANCING SOURCES						
Direct Appropriations Expended				$74,189	$24	$74,213
Employment Tax Revenue	$83,138		$83,138			83,138
SMI Premiums Collected		$14,683	14,683			14,683
Federal Matching Contributions		44,227	44,227			44,227
Revenue From Sales of Goods/Services						
CLIA User Fees					34	34
Intragovernmental\	1		1		4	5
Interest & Penalties (Non-Fed)					24	24
Interest (Fed)	10,609	1,941	12,550			12,550
Other Revenue and Financing Sources	1,198	1	1,199		140	1,339
Uncollected Revenue		(48)	(48)			(48)
HCFA Cost Allocation Adjustment, Net	105	(234)	(129)	129		
Transfers to FDA Pursuant to P.L. 103-50		(1)	(1)			(1)
Transfer of Catastrophic Assets	1,805	(1,805)				
Less: Collections for Principal Repayments Transferred To The Federal Financing Bank					26	26
Taxes and Receipts Transferred To the Treasury or Other Agencies					57	57
Total Revenues and Financing Sources	**$96,856**	**$58,764**	**$155,620**	**$74,318**	**$143**	**$230,081**
EXPENSES						
Program or Operating Expenses						
Medicare Benefit Payments	$87,756	$47,925	$135,681			$135,681
Medicaid Benefit Payments				$74,189		74,189
Administrative Expenses	837	1,721	2,558	139		2,697
Other					26	$26
Depreciation and Amortization	1	4	5			5
Interest Expense					11	11
Unfunded Expenses	(17)	(159)	(176)	(1,524)	(1)	(1,701)
Total Expenses	**$88,577**	**$49,491**	**$138,068**	**$72,804**	**$36**	**$210,908**
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	$8,279	$9,273	$17,552	$1,514	$107	$19,173
Net Position, Beginning Balance	110,905	12,776	123,681	2,117	2,739	128,537
Plus (Minus) Non-Operating Changes	3	(3)		8,406	1,263	9,669
Net Position, Ending Balance	**$119,187**	**$22,046**	**$141,233**	**$12,037**	**$4,109**	**$157,379**

STATEMENT OF CASH FLOWS BY ACTIVITY
FOR THE PERIOD ENDED SEPTEMBER 30, 1993

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
CASH FLOWS FROM OPERATING ACTIVITIES						
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	$8,279	$9,273	$17,552	$1,514	$107	$19,173
Adjustments Affecting Cash Flow						
Appropriations Expensed				($74,189)	($44,722)	($118,911)
Trust Fund Draws	($507)	($1,287)	($1,794)	(129)		(1,923)
Transfers to FDA Pursuant to P.L. 103-50		1	1			1
Decrease (Increase) in Accounts Receivable	(999)	(506)	(1,505)	(58)	(91)	(1,654)
Decrease (Increase) in Advances				14,428	(9)	14,419
Decrease (Increase) in Other Assets	8	30	38	3		41
Increase (Decrease) in Accounts Payable	(1,802)	(4,005)	(5,807)			(5,807)
Increase (Decrease) in Loans Payable					26	26
Increase (Decrease) in Interest Payable					1	1
Increase (Decrease) in Other Liabilities	18	(37)	(19)			(19)
Depreciation and Amortization	1	3	4	1		5
Other Unfunded Expenses		1	1	(1,524)		(1,523)
Suspense Account Deposit Funds					(2)	(2)
Total Adjustments	**($3,281)**	**($5,800)**	**($9,081)**	**($61,468)**	**($44,797)**	**($115,346)**
Net Cash Provided (Used) by Operating Activities	**$4,998**	**$3,473**	**$8,471**	**($59,954)**	**($44,690)**	**($96,173)**
CASH FLOWS FROM INVESTING ACTIVITIES						
Purchases of Property and Equipment	($1)	($3)	($4)			($4)
Net Cash Provided (Used) by Non-Operating Activities	**($1)**	**($3)**	**($4)**			**($4)**
CASH FLOWS FROM FINANCING ACTIVITIES						
Appropriations				$66,650	$45,973	$112,623
Add: Transfers from Medicare Trust Funds	$507	$1,287	$1,794	129		1,923
Transfers to FDA Pursuant to P.L. 103-50		(1)	(1)			(1)
Deduct: Withdrawals (M Year Funds)		1	1			1
Adjustment of Prior Year Cost Allocation	37	95	132	10		142
Net Appropriations	**$470**	**$1,190**	**$1,660**	**$66,769**	**$45,973**	**$114,402**
Purchase of Investments	($5,432)	($4,734)	($10,166)			($10,166)
Repayments on Loans from the Treasury and the Federal Financing Bank					($26)	(26)
Net Cash Provided (Used) by Financing Activities	**($4,962)**	**($3,544)**	**($8,506)**	**$66,769**	**$45,947**	**$104,210**
Net Cash Provided (Used) by Operating, Non-Operating and Financing Activities	$35	($74)	($39)	$6,815	$1,257	$8,033
Fund Balances With Treasury, Cash and Foreign Currency, Beginning	17	79	96	3,318	2,743	6,157
Fund Balances with Treasury, Cash and Foreign Currency, Ending	**$52**	**$5**	**$57**	**$10,133**	**$4,000**	**$14,190**

STATEMENT OF BUDGET AND ACTUAL EXPENSES BY ACTIVITY
FOR THE PERIOD ENDED SEPTEMBER 30, 1993

	(Dollars in Millions)					
	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
BUDGET:						
Resources	**$96,899**	**$58,873**	**$155,772**	**$86,913**	**$4,039**	**$246,724**
Total Obligations	**$88,837**	**$49,589**	**$138,426**	**$77,501**	**$53**	**$215,980**
BUDGET RECONCILIATION:						
Actual Expenses	**$88,577**	**$49,491**	**$138,068**	**$72,804**	**$36**	**$210,908**
Add:						
Capital Acquisitions	1	3	4			4
Less:						
Depreciation and Amortization	1	4	5			5
Unfunded Annual Leave Expense		1	1			1
Other Unfunded Expenses	(17)	(159)	(176)	(1,524)	(1)	(1,701)
Accrued Expenditures	**$88,594**	**$49,648**	**$138,242**	**$74,328**	**$37**	**$212,607**
Less: Reimbursements	1		1		5	6
Accrued Expenditures, Direct	**$88,593**	**$49,648**	**$138,241**	**$74,328**	**$32**	**$212,601**

Inspector General's Report on Financial Statements

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

INSPECTOR GENERAL'S REPORT
ON FINANCIAL STATEMENTS

To Bruce C. Vladeck
Administrator of Health Care Financing Administration

The Chief Financial Officers' (CFO) Act requires the Inspector General to audit the financial statements of the Health Care Financing Administration (HCFA) for the year ended September 30, 1993. The HCFA's management is responsible for (i) preparing financial statements in accordance with generally accepted accounting principles; (ii) complying with applicable laws and regulations; and (iii) maintaining an internal control structure that provides for the reliable financial reporting of all HCFA activities, including the 81 Medicare contractors who pay claims to beneficiaries.

We undertook this audit for the purpose of expressing an opinion on HCFA's financial statements and reporting on its internal control structure and compliance with laws and regulations. We are unable to express an opinion on HCFA's financial statements for the following reasons:

- Essential documentation in support of the Medicare accounts payable balance was not made available to us.
- Due to ineffective internal controls at Medicare contractor operations, it was not practical for us to audit the Medicare accounts receivable balance.
- Because HCFA did not have a financial management system, nor did it require the necessary documentation from the States, to properly record Medicaid accounts receivable, it was not practicable for us to expand our tests to a sufficient number of States.

We have been reviewing HCFA's financial operations for a number of years and have observed a trend of continuing improvement. However, due to the complexity of these issues and the expected limited funding available for improvements, several reporting periods may be needed to accomplish the necessary corrective actions before HCFA can present fully auditable financial statements.

REPORT ON FINANCIAL STATEMENTS

We were required to audit the accompanying HCFA combined financial statements as of and for the year ended September 30, 1993. The HCFA financial statements include the accounts of all funds it administers: the hospital insurance (HI) trust fund, the supplementary medical insurance trust fund, Medicaid grants, and the administrative costs of these funds. These financial statements are the responsibility of HCFA's management.

Limitations on our ability to apply certain audit procedures required by *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin 93-06, *Audit Requirements for Federal Financial Statements*, precluded us from expressing an opinion on HCFA's combined financial statements.

Beginning Balances. This was the second year that HCFA prepared financial statements as required by the CFO Act, and the first year that the statements were subjected to audit. Because our audit began after the start of the fiscal year (FY), we were unable to perform audit procedures necessary to substantiate account balances as of the beginning of FY 1993. Without the assurance that the opening balances were reliable, we could not determine HCFA's FY 1993 financial results.

Medicare Accounts Payable. The necessary documentation supporting the Medicare accounts payable balance of $14.16 billion, was not made available for us to test the actuarial determination of the account balance. Nor could HCFA provide sufficient data to enable us to substantiate the accounts payable balance using alternative auditing procedures.

Medicare Accounts Receivable. We were not able to apply sufficient audit procedures to satisfy ourselves as to the fair presentation of the reported Medicare accounts receivable balance of $3.03 billion. The internal controls over Medicare accounts receivable processing were not adequate to reduce, to a low level, the risk that the accounts receivable balance would be materially misstated and it was not practical for us to extend our audit procedures sufficiently to otherwise substantiate the account balance.

Medicaid Accounts Receivable. The HCFA does not have a financial reporting system that captures all Medicaid accounts receivable from the States, nor are the States required to report their accounts receivable to HCFA in accordance with generally accepted accounting principles. It was not practicable for us to extend our tests to a sufficient number of States to satisfy ourselves as to the fair presentation of the Medicaid accounts receivable balance.

Because of the significance of the matters discussed in paragraphs 3 through 6 above, and because we were not able to apply other auditing procedures to satisfy ourselves as to the fair presentation of the accounts involved, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the accompanying combined financial statements as of and for the period ending September 30, 1993.

Consistency of Other Information. We undertook the audit of HCFA's combined financial statements for the purpose of forming an opinion on these statements which, as described above, resulted in a disclaimer of opinion. The Overview and Supplemental Information is presented by HCFA for the purpose of additional analysis and is not a required part of the combined financial statements. This information has not been subjected to auditing procedures and, accordingly, we express no opinion on it.

MATTERS CONCERNING INTERNAL CONTROLS AND COMPLIANCE WITH LAWS AND REGULATIONS

We found four matters which involve weaknesses in internal controls or noncompliance with laws and regulations at HCFA and/or its Medicare contractors and which require management's attention. During the period of our review of the internal control structure, HCFA was in the process of modifying its policies and procedures to improve the controls over financial reporting at Medicare contractors. This included establishing procedures to report accurate accounts receivable and accounts payable balances. Although we generally noted improvements throughout the year at contractor operations, we continued to find significant weaknesses with the contractors' recording and reporting of financial results.

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The following paragraphs summarize these matters. They are discussed in greater detail in our report, *Report on the Health Care Financing Administration's Internal Controls Structure and Compliance with Laws and Regulations for the Fiscal Year Ended September 30, 1993* (A-14-93-03027), which also includes recommended corrective actions.

Medicare Accounts Receivable

The HCFA's internal control structure over Medicare accounts receivable did not reduce, to a relatively low level, the risk that material errors or irregularities may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. As required by the CFO Act and Federal Managers' Financial Integrity Act (FMFIA), Medicare contractors did not (i) effectively implement all the control procedures necessary to produce reliable financial information, (ii) have effective controls over segregation of duties and independent checks needed to prevent or detect misstatements on a timely basis, and (iii) maintain fully integrated general ledger accounting systems.

Our review disclosed that contractors did not have adequate controls and, as a result, they (i) did not properly estimate accounts receivable, (ii) used inconsistent methodologies to allocate accounts receivable to the appropriate trust funds, and (iii) did not reconcile the reported amounts with subsidiary accounts receivable records.

The HCFA's methodology for estimating the amount of the allowance for uncollectible accounts receivable was not reasonable because (i) HCFA did not have financial management systems in place to provide complete and accurate information on the status of accounts receivable, (ii) Medicare contractors did not consistently follow HCFA's directives for reporting receivable allowances, and (iii) HCFA relied on limited historical account collection data.

The HCFA's oversight of contractor operations did not provide reasonable assurance that internal control procedures were being effectively implemented. The HCFA's instructions to contractors did not adequately communicate internal control requirements, nor did HCFA's oversight procedures adequately evaluate internal controls at contractor operations. There was no assessment by HCFA to determine whether transactions were properly authorized, duties were adequately segregated, or independent checks were being performed.

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Medicaid Accounts Receivable

In reporting the balance of Medicaid accounts receivable, HCFA was not in compliance with the CFO Act, which requires complete, reliable, and timely financial information and provides the agency's chief financial officer with the authority to obtain required information from States.

Collections of Medicaid receivables were reported as refunds or offsets by the States on their Medicaid quarterly expenditure reports. Since HCFA had not established a financial system to account for and monitor Medicaid receivables, we performed tests of balances at selected States to determine the accuracy of the Medicaid accounts receivable balance. Although we determined that the account balance was not reliable, it was not practicable for us to extend our tests to a sufficient number of States to satisfy ourselves as to the fair presentation of the Medicaid accounts receivable balance.

Medicare Accounts Payable

The CFO Act requires the agency's chief financial officer to develop and maintain an integrated accounting and financial management system which complies with applicable accounting principles and provides for complete and reliable information. Sufficient documentation of this system should be made available to the auditors. The Office of the Actuary, which is responsible for determining the accounts payable balance using actuarial methods, did not provide us with sufficient documentation of the process and other data necessary to test the Medicare accounts payable balance. As an alternative, we attempted to perform other auditing procedures to substantiate the balance. However, HCFA was unable to provide us with computer-generated expenditure data as requested to perform such audit procedures.

The FMFIA directs each agency to make an annual evaluation of its internal controls using guidelines established by OMB. We found that no internal control review was performed at the Office of the Actuary. Such a review could have provided us sufficient documentation to rely on. We previously brought this to HCFA's attention in our review of HCFA's implementation of its FY 1993 FMFIA program.[1] The

[1] Draft report entitled *Review of the Health Care Administration's Implementation of the Federal Mangers' Financial Integrity Act for Fiscal Year 1993* (A-14-93-03026), dated November 15, 1993.

HCFA's position is that the functions of the Office of the Actuary, except for the personnel administrative functions, are a discretionary analytical process and not subject to the FMFIA program.

Wage Certifications

The Social Security Act requires that revenue be credited to the trust funds from employment payroll taxes and be based on employers' wage records established and maintained by the Secretary of Health and Human Services (HHS).

The Social Security Administration (SSA) determines the amount of the employment tax revenues transferred to the HI trust fund and certifies the amount to the Department of the Treasury. The SSA has been using Internal Revenue Service (IRS) data to provisionally certify wages, because it believes that is the correct amount, instead of wage reports maintained by the HHS. The SSA's final certification of wages and employment taxes cannot be determined until SSA and IRS have reconciled the wage and tax differences.

This unresolved issue could have a major impact on HCFA's reporting of the HI trust fund. Our audit[2] of SSA's financial statements as of September 30, 1993 concluded that the basis of transferring employment tax revenues was not in accordance with applicable laws and regulations. If the amount was recorded in accordance with applicable laws and regulations, the HI trust fund would decrease by about $2.4 billion.

MANAGEMENT'S RESPONSIBILITIES

The HCFA's management is responsible for:

- Designing and maintaining an internal control structure that provides reasonable, but not absolute, assurance that the following objectives are met:

  - transactions, including those related to obligations and costs, are executed in compliance with applicable laws and regulations;

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[2] *Audit of the Social Security Administration's Internal Accounting Controls and Compliance With Laws and Regulations for the Fiscal Year Ended September 30, 1993* (A-13-93-00408), dated February 8, 1994.

- funds, property, and other assets are safeguarded against waste, loss, and unauthorized use or misappropriation;
- transactions are properly recorded and accounted for to prepare reliable financial statements; and
- data that support related performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information.

- Preparing the financial statements in conformity with generally accepted accounting principles.
- Complying with laws and regulations including those that do not necessarily affect financial transactions or financial reporting.

AUDITOR RESPONSIBILITIES AND METHODOLOGIES

Our responsibilities are:

- To report the results of our tests of HCFA's internal control structure to the extent that its inadequate design or ineffective operation, if applicable, could materially affect HCFA's Combined Statement of Financial Position.
- To obtain an understanding of the internal control structure policies and procedures and assess the control risks applicable to HCFA's reported performance measurement data.
- To report the results of our related tests of HCFA's compliance with applicable laws and regulation that could materially affect the Combined Statement of Financial Position and those specified in OMB Bulletin 93-06.

Our tests of applicable internal controls and compliance were performed to determine the extent of our auditing procedures necessary for expressing an opinion on the Combined Statement of Financial Position and to report findings resulting from our

control and compliance testing and not to express, and we do not express, separate opinions about the adequacy of the internal control structure or compliance with laws and regulations.

Because of inherent limitations in any internal control structure, losses, noncompliance, or misstatement may nevertheless occur and not be detected. Also, projection of any evaluation of the internal control structure to future periods is subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with controls may deteriorate. Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be reportable conditions[3] and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses[4].

To fulfill these responsibilities we:

- Obtained an understanding of HCFA's internal control structure policies and procedures in conjunction with our attempted audit of HCFA's combined financial statements.

- Evaluated and tested the operation or the relevant internal control structure policies and procedures designed by management to provide reasonable, but not absolute, assurance that the above management objectives were met for the following significant cycles, classes of transactions, and account balances:

  - Medicare Accounts Receivable
  - Medicare Accounts Payable

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[3]A reportable condition is a matter coming to our attention related to a significant deficiency in the design or operation of the internal control structure that, in our judgement, could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

[4]A material weakness is a reportable condition in which the design or operation of one or more internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

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- Medicaid
- Treasury
- Investments
- Program Management

- Tested compliance with selected provisions of the following laws and regulations that may materially affect the financial statements or are specified in OMB Bulletin 93-06:

  - Social Security Act, as amended
  - Antideficiency Act
  - Budget Accounting and Procedures Act of 1950
  - CFO Act of 1990
  - FMFIA of 1982
  - Prompt Payment Act

- Compared the HHS' most recent FMFIA report on internal controls, that included HCFA, dated December 1993 with the results of our tests of internal controls.

June Gibbs Brown
Inspector General
Department of Health and Human Services

June 10, 1994

Glossary

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplemental Medical Insurance financing as determined by the difference between Trust Fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare administrative costs, Medicaid administrative costs, and HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays of the Program Management account, the PRO outlays, and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA, e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.. These costs are reflected in the Program Management account.

Beneficiary: A person entitled under the law to Medicare or Medicaid benefits; also referred to as "enrollee".

Benefit Payments: Funds outlayed for services delivered to beneficiaries.

Carrier: A private business, usually an insurance company, which contracts with HCFA to receive, review, and pay SMI claims.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

DSH (Disproportionate Share Hospital): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

DME (Durable Medical Equipment): Purchased or rented items such as hospital beds, wheelchairs or oxygen equipment, used in a patient's home.

ESRD (End Stage Renal Disease): Permanent kidney failure requiring dialysis.

Expenditure: Like outlays, expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

FICA (Federal Insurance Contribution Act) Payroll Tax: Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1993, employers and employees each contributed 1.45 percent of taxable annual wages up to $135,000 for Medicare.

Financial Statements: Combined statements of Financial Position (assets and liabilities) , Operations and Changes in Net Position (revenues and expenses) , Cash Flows (cash flows from operating, investing and financing activities), and Budget and Actual Expenses (resources and actual expenses).

FMAP (Federal Medical Assistance Percentage): The portion of the Medicaid program which is paid by the Federal government.

FMFIA (Federal Managers' Financial Integrity Act): A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

High Risk Area: A potential flaw in management controls requiring management attention and possible corrective action.

ICF/MR: Intermediate care facility for the mentally retarded.

Intermediary: A private business, usually an insurance company, which contracts with HCFA to receive, review, and pay HI benefit claims.

Internal Controls: Management systems of adequately documenting, monitoring, and correcting payment processes to avoid waste and ensure proper payment.

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management controls requiring high-priority corrective action.

Medicare Contractors: collective term for carriers and intermediaries.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

MR/UR (Medical Review/Utilization Review): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

MSP (Medicare Secondary Payer): A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Obligation: Budgeted funds committed to be spent.

Outlay: Budgeted funds actually spent.

Part A: Medicare Hospital Insurance, also referred to as "HI."

Part B: Medicare Supplementary Medical Insurance, also referred to as "SMI."

Payment Safeguards: Activities to prevent or recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

PRO (Peer Review Organization): PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and of acceptable quality.

Productivity Investments: Spending aimed at increasing contractor operational efficiency and productivity through improved work methods, application of technology, etc..

Program Management: HCFA's operational budget account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization providing medical services.

Recipient: An individual who receives Medicaid services.

SECA (Self Employment Contribution Act) Payroll Tax: Medicare's share of SECA is used to fund the HI Trust Fund. In FY 1993, self-employed individuals contributed 2.9 percent of taxable annual income up to $135,000 for Medicare.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Tax and Donations: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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Medicaid	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Financial Statements	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Notes	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Supplement	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Format	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Graphs	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**
Overall	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**

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U.S. Department of Health and Human Services

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